# PARA WEEKLY eMAGAZINE

*Improving The Business of HealthCare Since 1985*

*March 27, 2019*

PRICING • CODING • REIMBURSEMENT • COMPLIANCE

## IN THIS ISSUE



## PARA



## NEWS FOR HEALTHCARE DECISION MAKERS

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

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


## FAST LINKS




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# TREADMILL & NUCLEAR STRESS TEST RESEARCH

**Q.** We have been doing some research on Treadmills and Nuclear Stress Testing. Based on Medicare Reimbursement Information 2016 Lantheus Medical Imaging, it states that CPT® 93017 is included in CPT® 78452 (MPI Multiple Studies). Does that mean CPT® 93017 (tracing only) is also bundled into CPT® 78451 (MPI, single study)? Or should 93017 and 78451 be reported separately?

**A.** **Answer:** It's perfectly fine to report both 93017 and 78452 on the same claim. There is no overlap – 93017 is for the stress test, and 78452 is for imaging the heart during the test. There is no CCI edit preventing these two codes from being reported together.

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

Codes and/or Descriptions: **93017,78452**

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

| PRIME CPT | SECOND CPT | Edit Type | GB Modifier Indicator |
|---|---|---|---|
| 93017 - CARDIOVASCULAR STRESS TEST USING MAXIMAL OR SUBMAXIMAL TREADMILL OR BICYCLE EXERCISE, CONTINUOUS ELECTROCARDIOGRAPHIC MONITORING, AND/OR PHARMACOLOGICAL STRESS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT | 78452 - MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION | | OK to bill |

Our analysis of data on hospital outpatient claims submitted to Medicare in the January-June 2018 period indicates that when 78452 is reported, 93017 is also reported on the same claim over 94% of the time (nationally).

**Claim Summary**

Outpatient Medicare Limited Data Set - Calendar Year 2018

Geographic Market Group

2019 ADDB Query: 78452

| HCPCS Code | Description | APC Status | Reimbursement | | Hospital | Peer Group | National |
|---|---|---|---|---|---|---|---|
| **78452** | MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT) (INCLUDING ATTENUATION CORRECTION, QUALITATIVE OR QUANTITATIVE WALL MOTION, EJECTION FRACTION BY FIRST PASS OR GATED TECHNIQUE, ADDITIONAL QUANTIFICATION, WHEN PERFORMED); MULTIPLE STUDIES, AT REST AND/OR STRESS (EXERCISE OR PHARMACOLOGIC) AND/OR REDISTRIBUTION AND/OR REST REINJECTION | S | 1,152.89 | APC | 27 1,309 Total Claims<br>1,517 Peer Claims<br>19 Hospital Claims | | |
| 93017 | CARDIOVASCULAR STRESS TEST USING MAXIMAL OR SUBMAXIMAL TREADMILL OR BICYCLE EXERCISE, CONTINUOUS ELECTROCARDIOGRAPHIC MONITORING, AND/OR PHARMACOLOGICAL STRESS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT | Q1 | 236.61 | APC | 78.9 % | 99.9 % | 94.4 % |
| 93018 | CARDIOVASCULAR STRESS TEST USING MAXIMAL OR SUBMAXIMAL TREADMILL OR BICYCLE EXERCISE, CONTINUOUS ELECTROCARDIOGRAPHIC MONITORING, AND/OR PHARMACOLOGICAL STRESS; INTERPRETATION AND REPORT ONLY | 8 | 14.75 | PROFEE | | | 1.4 % |
| 93225 | EXTERNAL ELECTROCARDIOGRAPHIC RECORDING UP TO 48 HOURS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; RECORDING (INCLUDES CONNECTION, RECORDING, AND DISCONNECTION) | Q1 | 99.85 | APC | | 0.2 % | 0.7 % |
| 93226 | EXTERNAL ELECTROCARDIOGRAPHIC RECORDING UP TO 48 HOURS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; SCANNING ANALYSIS WITH REPORT | Q1 | 99.85 | APC | | | 0.5 % |

## CRNA CHARGES

**Q.** We have CRNAs wanting to charge for certain line insertions (ex. Swan-Ganz, Central Line, Arterial Line, and PICC Line) when they are doing another procedure. We want to charge for the professional fee for the CRNA. Can we use revenue code 0964 on these professional charges so that it can go to the 1500?

**A.** **Answer:** Yes, revenue code 0964 is the correct revenue code for reporting CRNA charges, although the payer will not see the revenue code when submitting a claim on a CMS1500/837p professional fee claim form (there is no field for revenue code on that form.) Charges should be routed to a CMS1500/837p claim form.

**Revenue Codes**

Codes and/or Descriptions: **0964**

Export to PDF | Expc

| Code | Description |
|---|---|
| 0964 | PROFESSIONAL FEES (ALSO SEE 097X AND 098X) - ANESTHETIST (CRNA) |

## FINANCIAL ASSISTANCE AND MEDICARE BAD DEBT

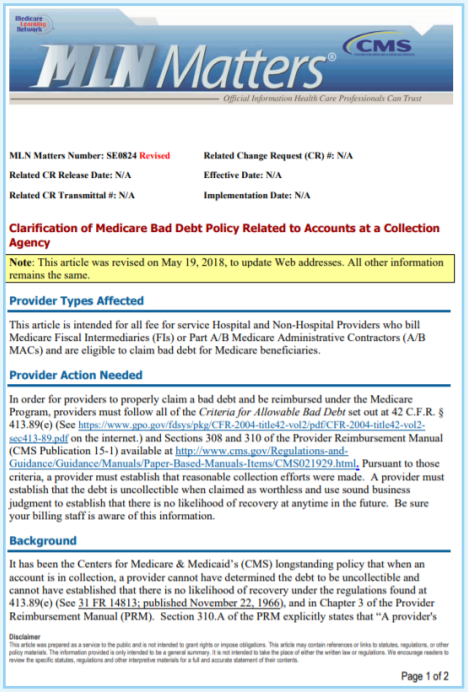
**Q.** We have a financial assistance program that we have established for patients who qualify. My question is if it is appropriate for patients with Medicare to apply and qualify for this in house program or if they should just be reported as Medicare Bad Debt at the end of the year.

**A.** **Answer:** The hospital may not characterize financial assistance write-offs as Medicare Bad Debt. Medicare Bad Debt is reported exclusively for patient liability which has not been forgiven under a financial assistance program, and which debt has been pursued.

Here's a link and an excerpt from a May, 2018 CMS transmittal regarding bad debt:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0824.pdf

"... a provider must establish that reasonable collection efforts were made. A provider must establish that the debt is uncollectible when claimed as worthless and use sound business judgment to establish that there is no likelihood of recovery at any time in the future."



MLN Matters®

Official Information Health Care Professionals Can Trust

MLN Matters Number: SE0824 Revised | Related Change Request (CR) #: N/A

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

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

**Clarification of Medicare Bad Debt Policy Related to Accounts at a Collection Agency**

**Note**: This article was revised on May 19, 2018, to update Web addresses. All other information remains the same.

**Provider Types Affected**

This article is intended for all fee for service Hospital and Non-Hospital Providers who bill Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) and are eligible to claim bad debt for Medicare beneficiaries.

**Provider Action Needed**

In order for providers to properly claim a bad debt and be reimbursed under the Medicare Program, providers must follow all of the *Criteria for Allowable Bad Debt* set out at 42 C.F.R. § 413.89(e) (See https://www.gpo.gov/fdsys/pkg/CFR-2004-title42-vol2/pdf/CFR-2004-title42-vol2-sec413-89.pdf on the internet.) and Sections 308 and 310 of the Provider Reimbursement Manual (CMS Publication 15-1) available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html. Pursuant to those criteria, a provider must establish that reasonable collection efforts were made. A provider must establish that the debt is uncollectible when claimed as worthless and use sound business judgment to establish that there is no likelihood of recovery at anytime in the future. Be sure your billing staff is aware of this information.

**Background**

It has been the Centers for Medicare & Medicaid's (CMS) longstanding policy that when an account is in collection, a provider cannot have determined the debt to be uncollectible and cannot have established that there is no likelihood of recovery under the regulations found at 413.89(e) (See 31 FR 14813; published November 22, 1966), and in Chapter 3 of the Provider Reimbursement Manual (PRM). Section 310.A of the PRM explicitly states that "A provider's

Disclaimer

Page 1 of 2

## OSTOMY MARKING

**Q.** If our nurses become Certified Ostomy Care Nurse (COCN) certified, do we bill their services on a UB or 1500? I think it is UB but the we researched 99201 thru 99215 for their services so we am a little confused as to what their certification means as far as billing goes. Can you clarify?

**A.** **Answer:** COCN does not qualify a nurse for pro fee billing. In the facility setting, the services of a COCN would be reported only on a UB04 in the facility setting. The code range 99201-99215 would be appropriate for commercial/non-Medicare payors (although some may accept the Medicare outpatient visit HCPCS G0463.)

In a freestanding clinic setting, services provided by a COCN may be billed "incident to" an enrolled clinician – meaning that their services are billed as rendered by the supervising physician. There is no "incident to" billing in the facility setting. I have attached our paper on "incident to" billing.

The list of non-physician clinicians which are eligible for enrollment by Medicare for professional fee claims is found on the CMS 855i enrollment form, see page 7:

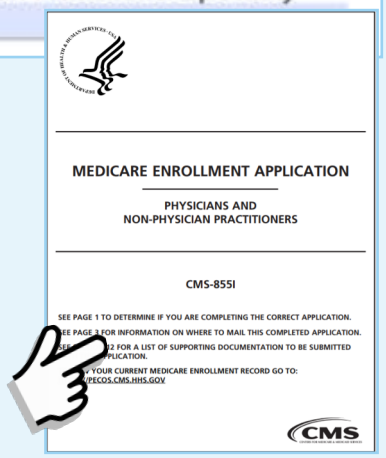
https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855i.pdf

**MEDICARE ENROLLMENT APPLICATION**

**PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS**

- ☐ 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)*: _____


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 PAGE 2 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

Note that PTs and OTs enroll only if they are in private practice, they do not need to enroll when practicing at a hospital outpatient department.

# TMS 90867 AND 90868 BILLING

**Q.** We have question about TMS (90867 and 90868) billing. If TMS services provided in hospital based facility and physician is not employed by hospital, can hospital bill facility charges and physician bill professional charges?

**A.** **Answer:** Unfortunately, the objective data we would normally use to definitively answer this question is not available in the Medicare Physician Fee Schedule. Attached is our paper on identifying HCPCS which are eligible for split billing, but the payment policy indicators are not available for these CPT® codes within the Medicare Physician Fee Schedule – they are "contractor priced." You may want to reach out to your Medicare Administrative Contractor to inquire what the TC/PC payment policy indicator is for these codes – it is not published in the MPFS.

However, based on the description of the codes, we are reasonably confident that both a facility fee and a professional fee can be reported when this service is performed in the hospital setting. The hospital reimbursement reflects the equipment and care environment resources, the physician's fee would represent personal supervision and attendance during the procedure.

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

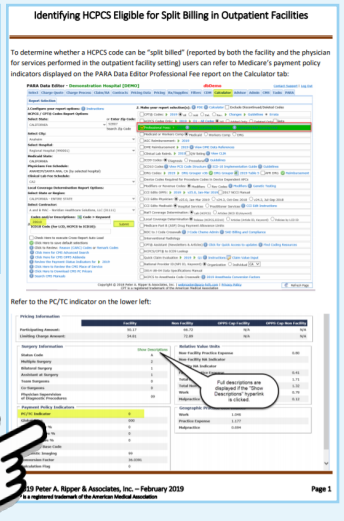
Codes and/or Descriptions: **90867,90868** for selected Provider:
Results returned(below): 2
AWI: **1.0206**, DME: **CO**, Clinical Lab Fee Schedule: **CO**, Physician Fee Schedule:**COLORADO**

Export to PDF | Export to Excel | Physician Supervision Definitions

| | | | | |
|---|---|---|---|---|
| 90867 - therapeutic repetitive transcranial magnetic stimulation (tms) treatment; initial, including cortical mapping, motor threshold determination, delivery and management<br>**S - Paid Under OPPS; Separate APC.** | Contractor Priced | 5722 - Level 2 Diagnostic Tests and Related Services | Weight:<br>Payment:<br>National Co-pay:<br>Minimum Co-pay: | 3.1741<br>$255.43<br>$0.00<br>$51.09 |
| 90868 - therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent delivery and management, per session<br>**S - Paid Under OPPS; Separate APC.** | Contractor Priced | 5721 - Level1 Diagnostic Tests and Related Services | Weight:<br>Payment:<br>National Co-pay:<br>Minimum Co-pay: | 1.7103<br>$137.63<br>$0.00<br>$27.53 |

We found the attached reimbursement guides from a vendor website which sells the equipment required for these procedures; it is apparent that they are of the opinion that both a facility fee and a professional fee are reported for services in the outpatient setting.

Here is a link and a snip from the website where I found this information:
https://neurostar.com/hcp/reimbursement-support/coding-and-billing-for-neurostar-tms-therapy/

# SNF PROVIDERS: WHAT IS THE PATIENT-DRIVEN PAYMENT MODEL?

***Editor's Note: This article originally appeared three weeks ago. It has been updated to reflect new information.***

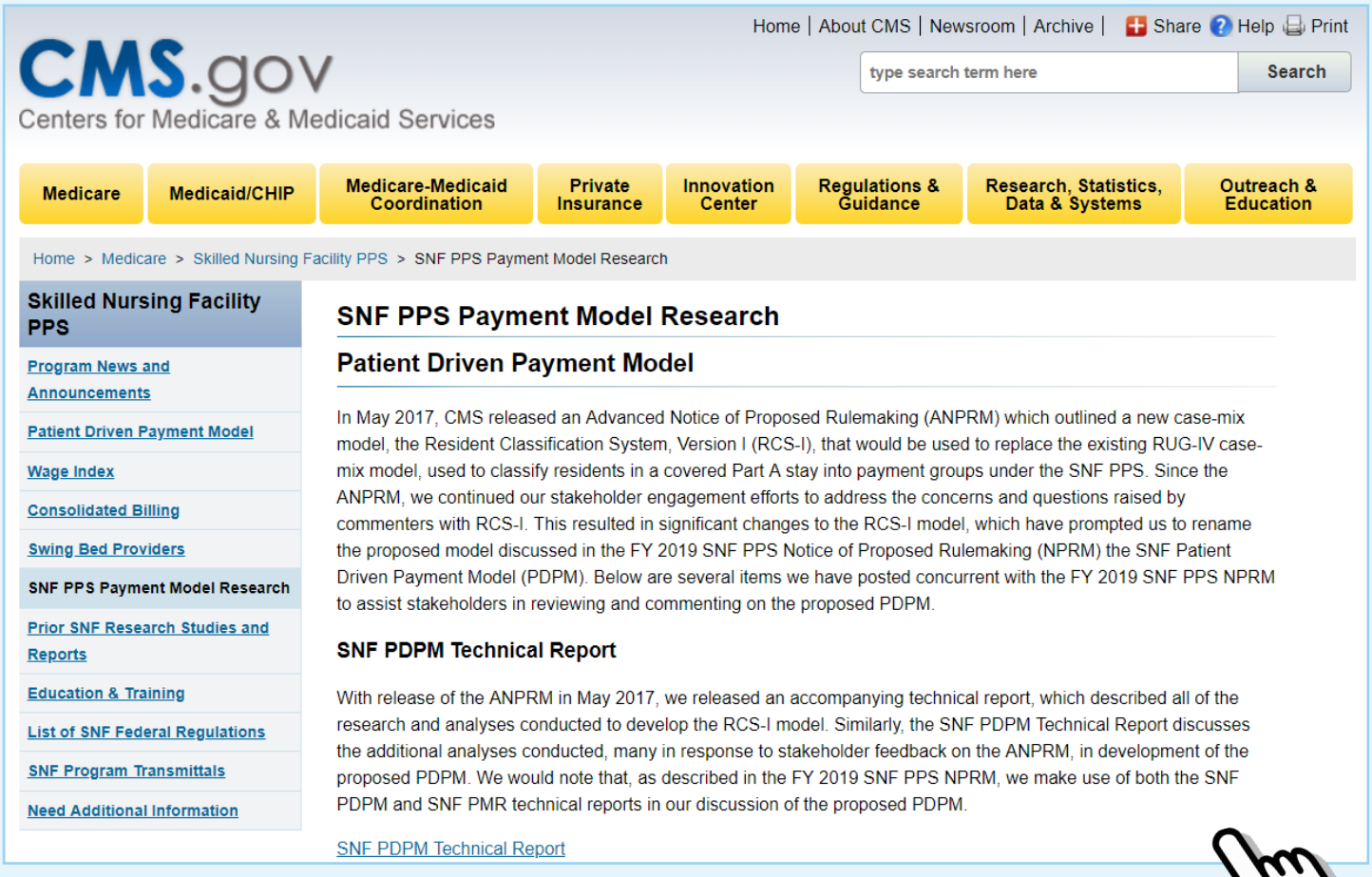
Update

What is the Long-Term Care / SNF Patient-Driven Payment Model or PDPM?

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

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

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




**This payment model is expected to be implemented beginning October 01, 2019 and will impact SNF providers billing under type of bill (TOB) 21X, as well as hospital swing-bed providers billing under TOB 18X.**

# SNF PROVIDERS: WHAT IS THE PATIENT-DRIVEN PAYMENT MODEL?

**Overview of Case-Mix Categories:**

Within the new PDPM, resident characteristics will determine the clinical category for care. There are 10 clinical categories for care:

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

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

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

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

The five designated case mix components are:

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

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

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

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

## SNF PROVIDERS: WHAT IS THE PATIENT-DRIVEN PAYMENT MODEL?

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

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

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

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

## SNF PROVIDERS: WHAT IS THE PATIENT-DRIVEN PAYMENT MODEL?

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

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

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

Payments for Nursing and Speech/Language Pathology will remain constant through the resident's stay however, PT, OT and Non-therapy Ancillaries will see variable rates over the length of stay.

PT and OT will see downward adjustments of 2% at day 20 and then a further 2% decrease every 7th day thereafter. NTA will decrease by two-thirds starting at day four (4).

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

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

# SNF PROVIDERS: WHAT IS THE PATIENT-DRIVEN PAYMENT MODEL?

The table inserted on the next page demonstrates the basic difference between RUGs IV and PDPM:

| Item | RUGs IV | PDPM |
|---|---|---|
| Definition | Residents are classified into a RUG grouper based on the care provided for the period covered.<br>Residents can fall into more than one RUG score in this methodology, but the one with the highest associated case-mix index is used for reimbursement. | Residents are classified into one of 10 clinical categories based on primary diagnosis.<br>The category determines the case-mix index OT and PT. Nursing uses PDPM RUG. SLP and Non-therapy Ancillaries are determined by co-morbidities present.<br>The indexes are added together and combined with a non-case mix component for the total daily rate reimbursed. |
| Case Mix Components | Nursing<br>Therapy (PT, OT, SLP) | Physical therapy (PT)<br>Occupational Therapy (OT)<br>Speech/Language Pathology (SLP)<br>Non-therapy Ancillary (NTA)<br>Nursing |
| ADL/Function Scoring | MDS Section G | MDS Section GG |
| Total Number of groups | 66 | 28, 800<br>PT/OT – 16 groups<br>SLP – 12 groups<br>NTA – 6 groups<br>Nursing – 25 groups |
| Reimbursement | 1. # of minutes of therapy<br>2. Nursing Service delivered<br>-Payment is uniform through the period covered by the MDS assessment | 1. Clinical Category/Nursing PDPM RUG<br>2. Function Score (Therapy minutes not counted toward reimbursement)<br>- Nursing and SLP rates remain constant<br>- OT/PT rates decline over LOS -2% for every 7 days after day 20<br>- NTA rates decline after day 3 by 2/3rd |
| MDS Assessments | 5 Scheduled MDS assessments:<br>- 5-day<br>- 14-day<br>- 30-day<br>- 60-day<br>- 90-day<br>Additional Unscheduled Assessments:<br>- Other Medicare Required Assessment<br>- Start of Therapy<br>- Change of Therapy<br>- End of Therapy<br>- Significant Changes in Condition<br>- Discharge Assessment | 1 Scheduled MDS Assessment<br>- 5- day<br>Additional Unscheduled Assessments:<br>- Discharge Assessment<br>- Interim Payment Assessment<br><br>An IPA will be rare and will be required in the following circumstances:<br>1. For all Part A residents on transition to PDPM<br>2. When these criteria are met: there is a changed in first tier classification AND the resident would not be expected to return to original status in 14 days. |

## SNF PROVIDERS: WHAT IS THE PATIENT-DRIVEN PAYMENT MODEL?

**Recommendations for preparing for PDPM Implementation:**

- Providers should begin by reviewing current processes from end-to-end. This activity will assist in determining what processes will need to be changed to meet the criteria for PDPM
- Training staff on the shift in data capture will be a key point to a successful PDPM implementation. For example, staff need to ensure that all diagnoses and conditions are collected as soon as possible to ensure accurate coding on the MDS
- Coding staff will need it identify the primary diagnosis that maps to a clinical category where possible
- Communicating to physicians about the upcoming changes and educating them on the new categories and importance of a correct diagnosis is critical for a successful adoption of PDPM
- Review of therapy contracts is critical for identifying the business impact from the therapy perspective to avoid any surprises once the facility implements PDPM

**For this transition, CMS is anticipating that days paid under RUGs-IV would stop on September 30, 2019 and days would be paid under PDPM beginning October 01, 2019. All other adjustment factors, such as geographic wage costs variations, will remain the same as they currently are under SNF PPS.**

## FEATURED PRODUCT: PATIENT SHARE OF COST WIDGET

***Pricing transparency continues to be an important topic in the healthcare industry. Healthcare professionals are working to understand how pricing transparency can improve Patient satisfaction and reduce hospital bad debt.***

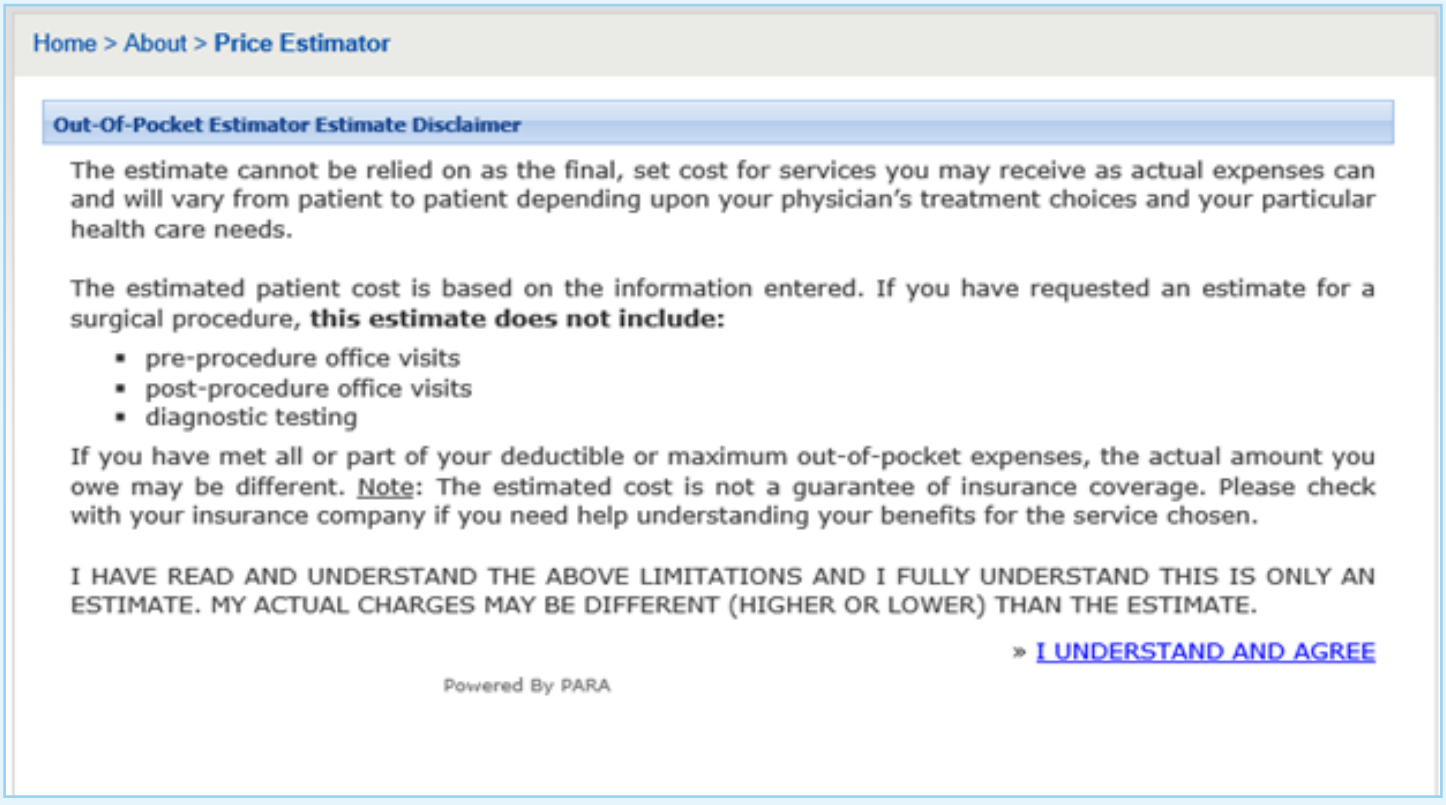
The benefits of providing cost estimates prior to schedule services include:

- Providing pricing transparency
- Provide estimates prior to service, avoiding unexpected financial liability
- Reduce Patient dissatisfaction directed at the provider
- Increase self-pay collections while decreasing bad debt

Today's patients are becoming informed consumers through a variety of channels including media exposés on healthcare costs and the continued progress of the Affordable Care Act. Patients require a clear picture of their financial obligation for services. Informing Patients of the cost of services is in the best interest of the facility.

Although generating a quote for services involves a variety of contractual discounts and health insurance plan information, some information can be readily available to the Patient with minimal employee intervention.

The **PARA Patient Share of Cost Estimator Widget** allows the Patient to determine their cost from a provider-based web portal.



# FEATURED PRODUCT: PATIENT SHARE OF COST WIDGET

PARA Product

## THE PARA SOLUTION:

The **PARA Patient Share of Cost Estimator Widget** provides facilities with a system for generating Patient quotes of the top procedures for the facility.

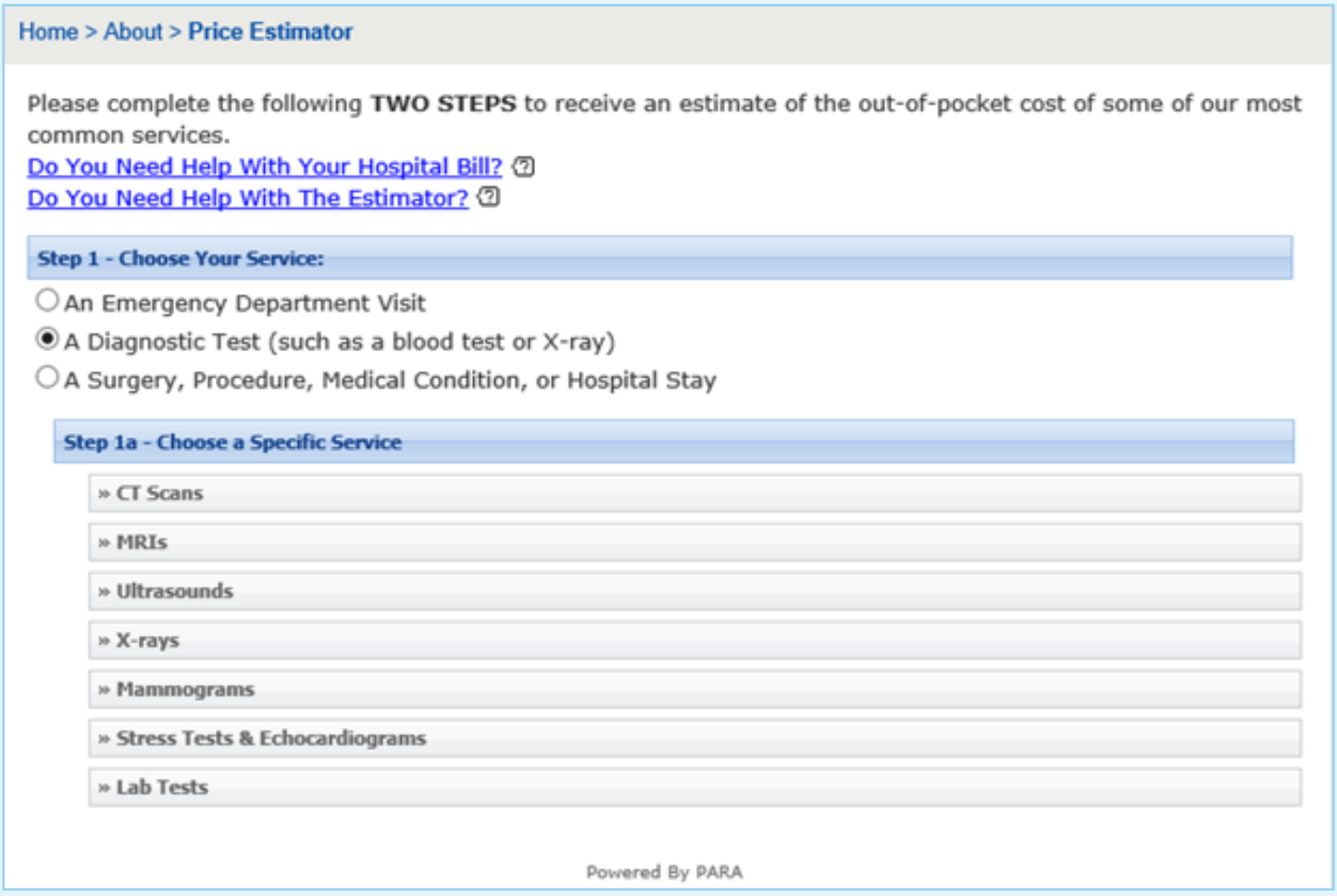
Details of this project including purpose, method, timeline, and deliverables are as follows. If you would like more information, please contact your Account Executive.

## PURPOSE:

The purpose of the **PARA Patient Share of Cost Estimator Widget** is to create a web-based system that allows the Patient to determine their share of cost for healthcare services.

## METHOD:

**PARA** will review your current website design structure to create a patient cost estimator widget mirroring the look and structure of your current website. The PARA Patient Share of Cost Estimator Widget provides the patient an easy to use decision tree to select the services required.



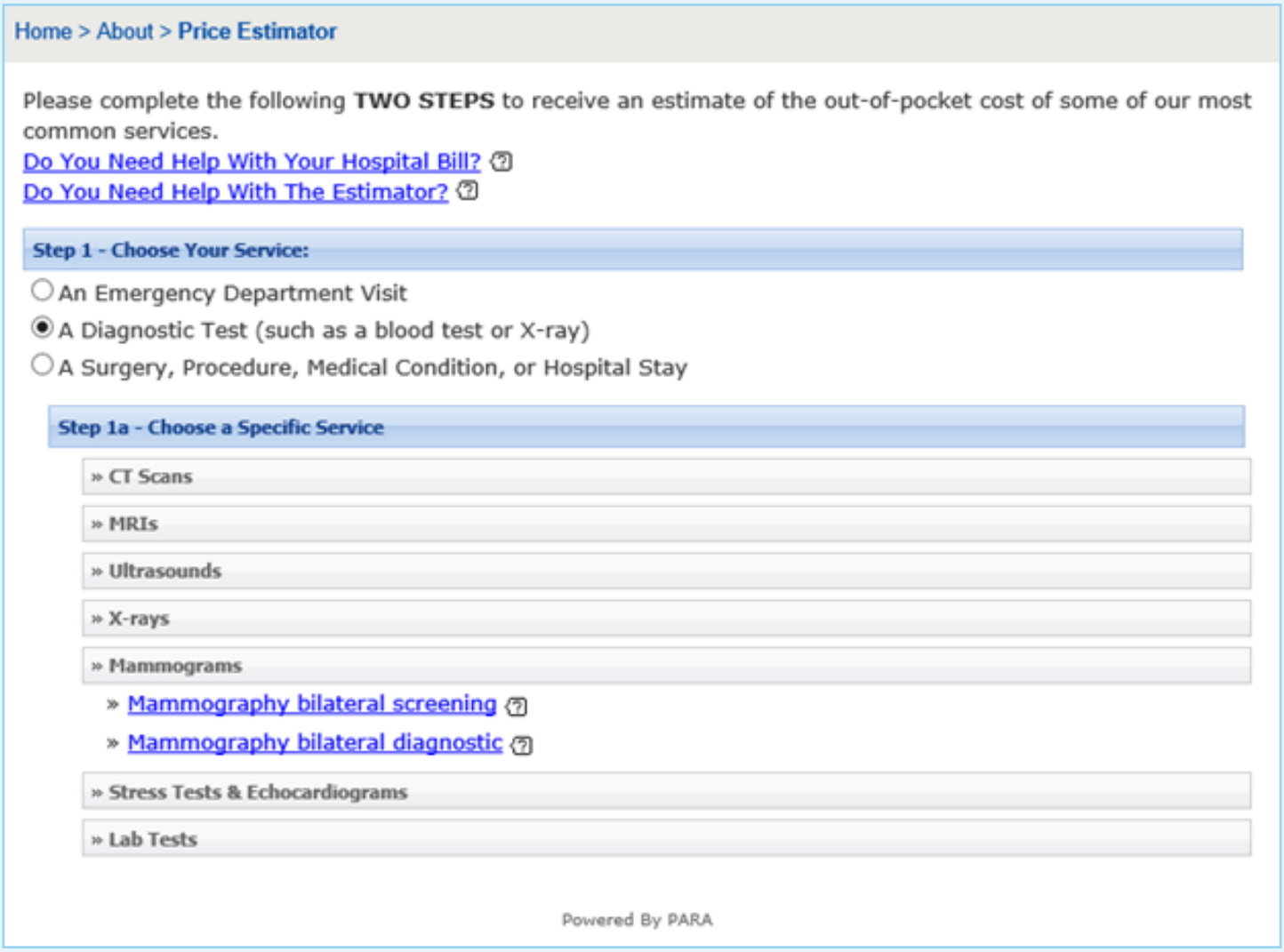
## FEATURED PRODUCT: PATIENT SHARE OF COST WIDGET

PARA Product

**PARA** will provide your facility a suggested list of services based on trends of the most recent Medicare Data available including:

- All Inpatient Medicare DRG Data
- Top 25 ICD-10 Diagnoses for ED Level Charges
- New and Established Patient Level Samples
- Mammography Charges
- Top 50 EKG/Stress Test Charges
- Top 25 Laboratory Procedures
- Top 25 Radiology Procedures
- Other Service Lines (as requested by client)

**PARA** will develop custom procedure categories and subcategories based on the facility-approved list of services and will develop and provide the implementation instructions for facility and designated Employers for immediate deployment. Initial and ongoing training and support for the duration of the agreement for Employers and facility are provided.



# FEATURED PRODUCT: PATIENT SHARE OF COST WIDGET

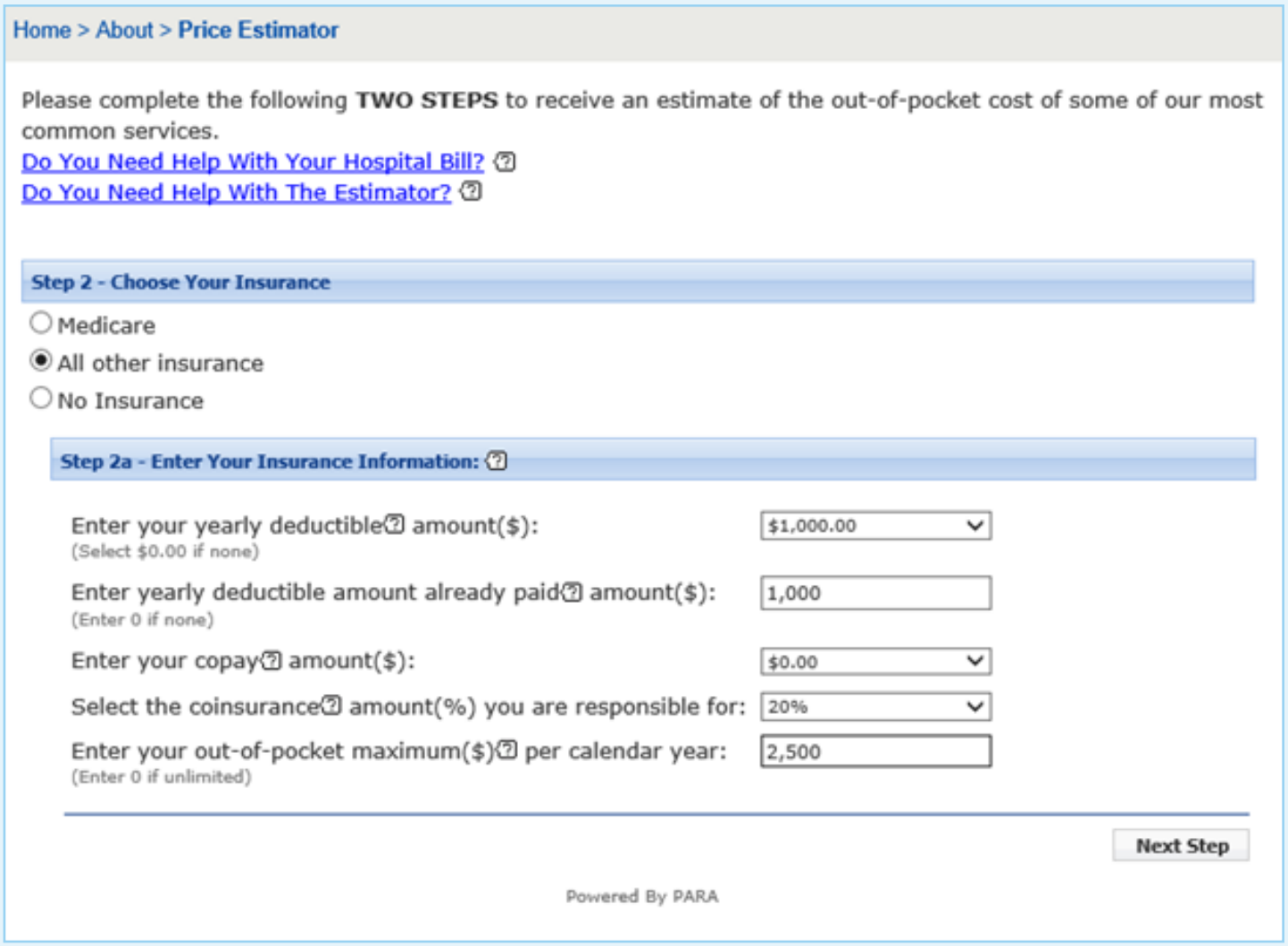
PARA Product

## DELIVERABLES:

**PARA** will provide your facility a web-based control panel to allow updates and changes to the estimator on an ongoing basis (e.g. update prices, change benefit plans, add services, etc.)

**PARA** will provide an optional insurance and benefit plan allowing any patient to enter their own benefit information to calculate their cost.

**PARA** will provide Medicare and Medicaid terms (where applicable) allowing patients to calculate their cost, and will incorporate the hospital's self-pay discount to allow self-pay patients to calculate their cost.

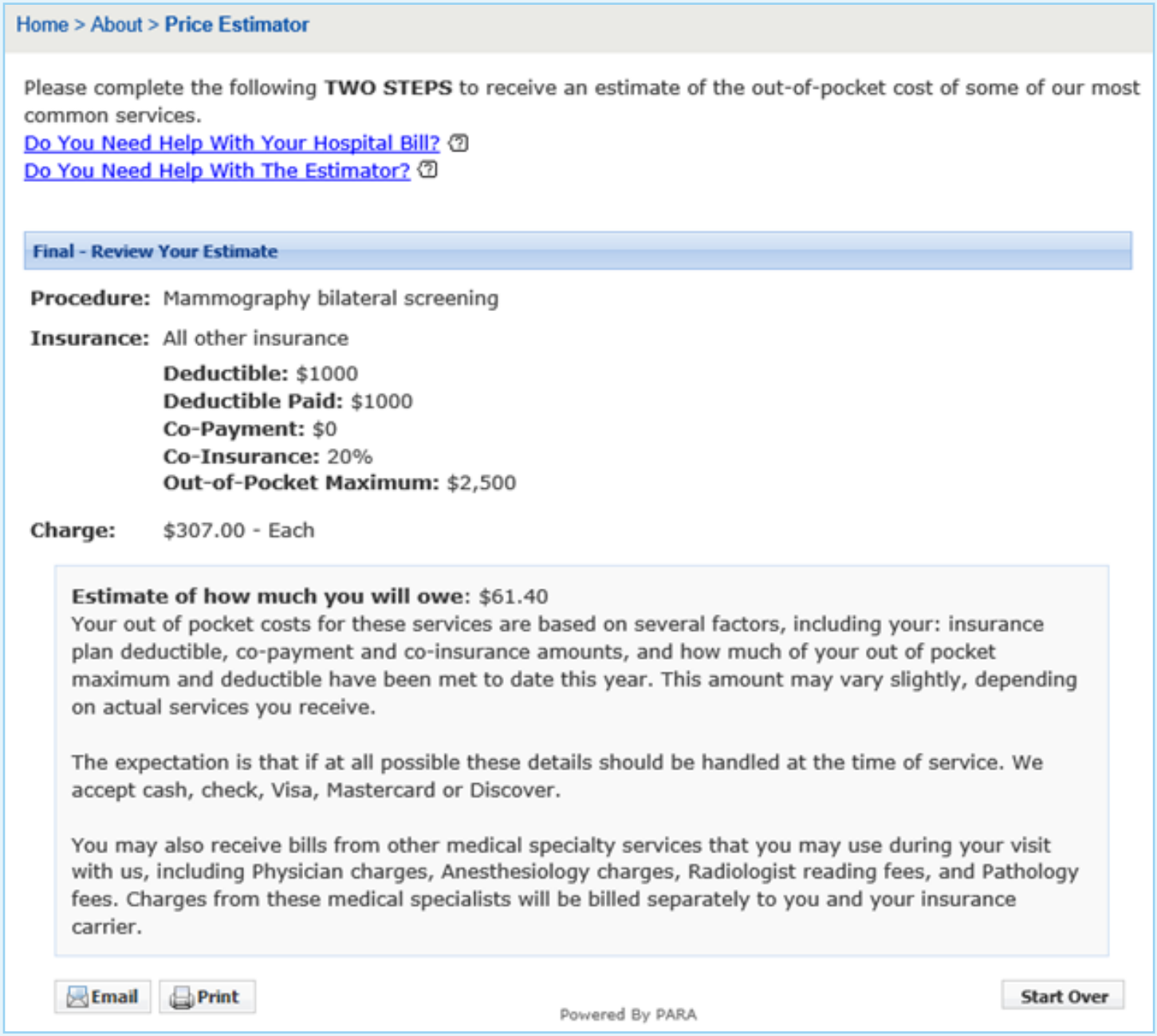


## FEATURED PRODUCT: PATIENT SHARE OF COST WIDGET

PARA Product

**PARA** will provide an option for the price estimate to be emailed to the patient or printed and will provide links and referrals to financial counseling, charity care policies, quality ratings, patient satisfaction scores, and other information deemed pertinent by the hospital.

**PARA** will provide an internal web-based tool to the provider to review all estimates created by Patients.



Home > About > Price Estimator

Please complete the following **TWO STEPS** to receive an estimate of the out-of-pocket cost of some of our most common services.

Do You Need Help With Your Hospital Bill?

Do You Need Help With The Estimator?

**Final - Review Your Estimate**

**Procedure:** Mammography bilateral screening

**Insurance:** All other insurance

**Deductible:** $1000
**Deductible Paid:** $1000
**Co-Payment:** $0
**Co-Insurance:** 20%
**Out-of-Pocket Maximum:** $2,500

**Charge:** $307.00 - Each

**Estimate of how much you will owe:** $61.40

Your out of pocket costs for these services are based on several factors, including your: insurance plan deductible, co-payment and co-insurance amounts, and how much of your out of pocket maximum and deductible have been met to date this year. This amount may vary slightly, depending on actual services you receive.

The expectation is that if at all possible these details should be handled at the time of service. We accept cash, check, Visa, Mastercard or Discover.

You may also receive bills from other medical specialty services that you may use during your visit with us, including Physician charges, Anesthesiology charges, Radiologist reading fees, and Pathology fees. Charges from these medical specialists will be billed separately to you and your insurance carrier.

Email Print

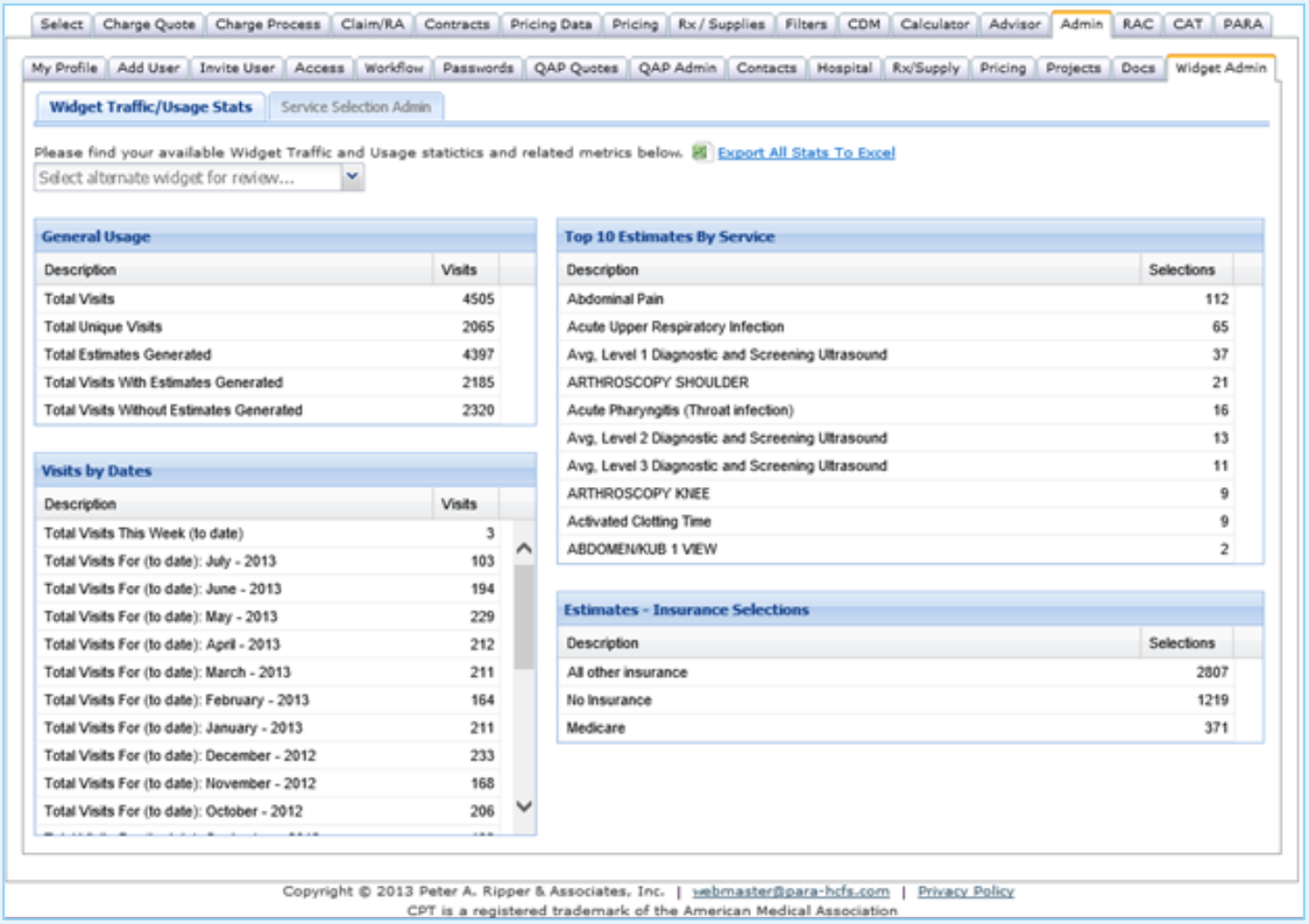
Powered By PARA

Start Over

# FEATURED PRODUCT: PATIENT SHARE OF COST WIDGET

PARA Product

The **PARA Patient Share of Cost Estimator Widget** statistics can be tracked in the **PARA Data Editor (PDE)** according to general use, visits by date, top estimates by service, and estimates by insurance.




## Built in Protection of the Hospital Managed Care Contract Terms

The ability to calculate patient estimates on your website will be provided upon the consumer's ability to input their specific plan details.

**PARA** has also developed the ability to integrate contracts and in doing so have added additional layers of protection, so the **Patient Share of Cost Widget** becomes a more accurate tool for providing price estimates.

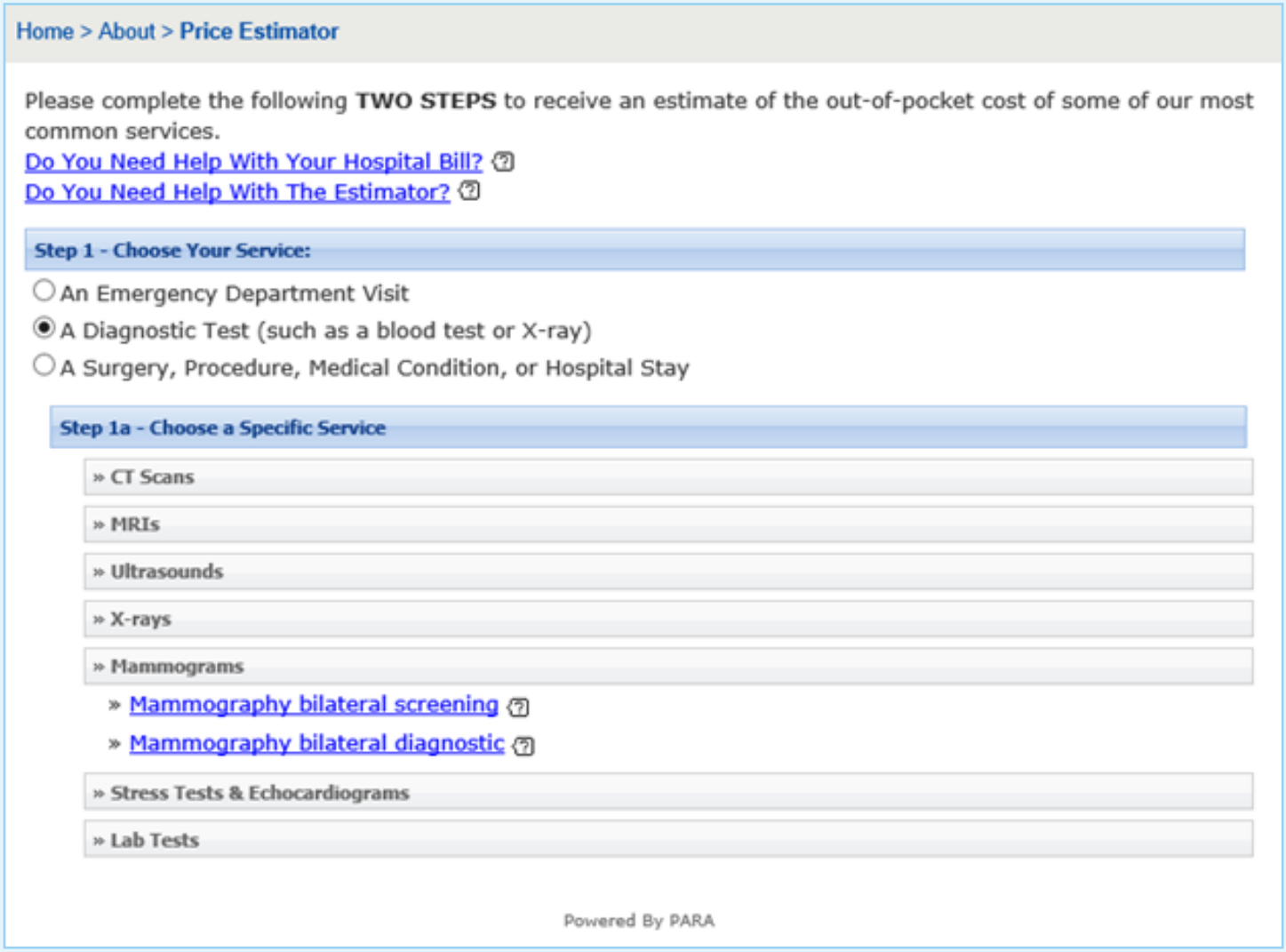
However, by including this additional functionality, competitors and other malicious users may attempt to take advantage of the tool to shop prices.

**PARA** is further developing the ability to protect your facility from such attacks by folding in user eligibility checking before proceeding to view the final estimate to ensure proper usage.

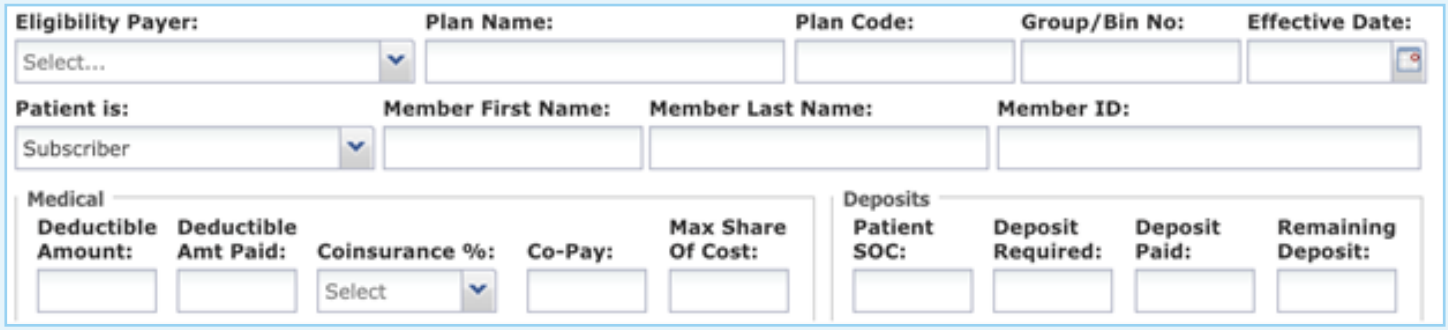
## FEATURED PRODUCT: PATIENT SHARE OF COST WIDGET

PARA Product

After the consumer has responded to "Step 1a – Choose a Specific Service," the patient would then be able to view only the gross charges for the service(s) they have selected.




Once they have viewed the charges, the patient will be asked to complete an Eligibility Form which asks for their personal insurance information, as shown below:

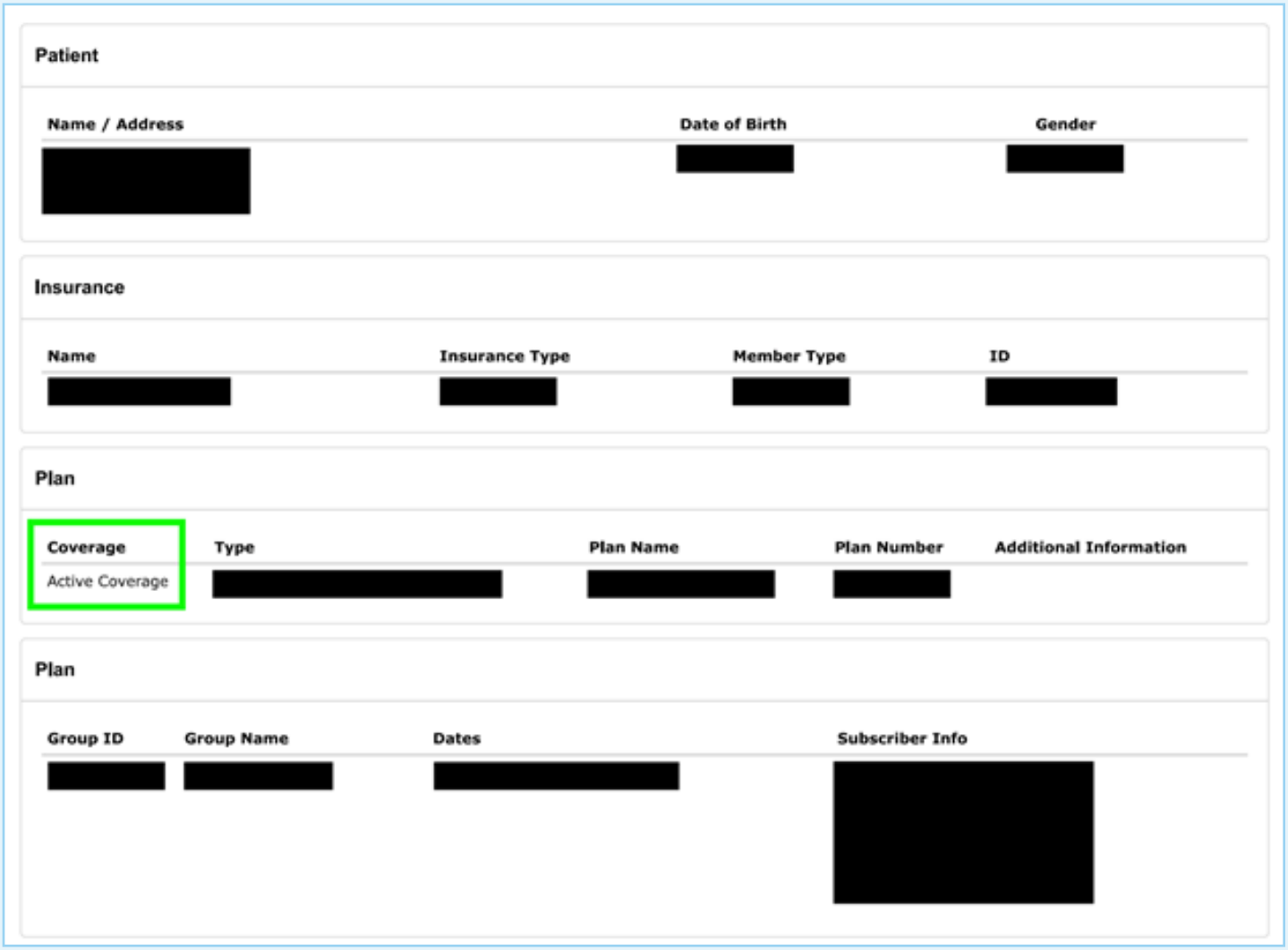


PARA Product

## FEATURED PRODUCT: PATIENT SHARE OF COST WIDGET

Once the user has input their information and chosen to perform the check, **PARA** takes this information and communicates via an Electronic Data Interchange (EDI) linkage to the patient's insurance plan to confirm coverable, copays, and deductibles.

A successful verification response, as shown below, ensures a further level of protection to avoid data mining from outside parties:




Only when **PARA** hears back that the check has been successful will the user be able to proceed to view their final estimate.

Further functionality will be developed in order to save the results from the eligibility check and the final estimate for the user to review the quote on a later date. This will be accomplished by asking the Patient for their email address and sending a secure link via email to reopen the results.

Links emailed to users will also be used when the eligibility check does not return an immediate result. The user will be notified once a result has been received and whether they can proceed to open their requested quote.


## FEATURED PRODUCT: PATIENT SHARE OF COST WIDGET

### SAMPLES OF PRICE TRANSPARENCY WITH PARA'S PRICE ESTIMATOR DECISION TREE WIDGET:

**Price Transparency Link and Cost Estimations for Medicare and No Insurance:**


**Price Transparency Link and Patient Estimates using PARA's standard Decision Tree for Insurance, Medicare and Self-Pay:**



**Price Transparency Link built into PARA's custom landing page for Hospital Defined Services and providing Patient Estimates with PARA's standard Decision Tree for Insurance, Medicare and Self-Pay:**


**Price Transparency Link built into PARA's custom landing page for direct Cost Estimations regardless of payer:**


**Price Transparency Link broken out by location with direct Cost Estimations also dependent on location:**

# HOSPITAL BEDS AND ACCESSORIES: PROVIDER COMPLIANCE TIPS

**In 2017, the Medicare Fee-For-Service (FFS) improper payment rate for hospital beds and accessories was 78.5 percent, with projected inaccurate payments of $66.2 million. Improper payments resulted from insufficient documentation.**

Prevent denials by reviewing the Provider Compliance Tips for Hospital Beds and Accessories Fact Sheet, which details general requirements, coverage, and documentation requirements for:

- Physician's prescription
- Variable height feature
- Electric powered adjustments
- Side rails

mln
FACT SHEET
PRINT-FRIENDLY VERSION
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PROVIDER COMPLIANCE TIPS
FOR HOSPITAL BEDS AND ACCESSORIES

PROVIDER TYPES AFFECTED

Physicians and other practitioners who write requisitions or orders for hospital beds and accessories

BACKGROUND

The Medicare Fee-For-Service (FFS) improper payment rate for hospital beds and accessories for the 2017 reporting period was 78.5 percent, representing a projected improper payment amount of $66.2 million and accounting for 0.2 percent of the overall Medicare FFS improper payment rate.

REASONS FOR DENIALS

During the 2017 reporting period, the majority of improper payments for hospital beds and accessories were due to insufficient documentation.

Page 1 of 3 ICN 909476 February 2018

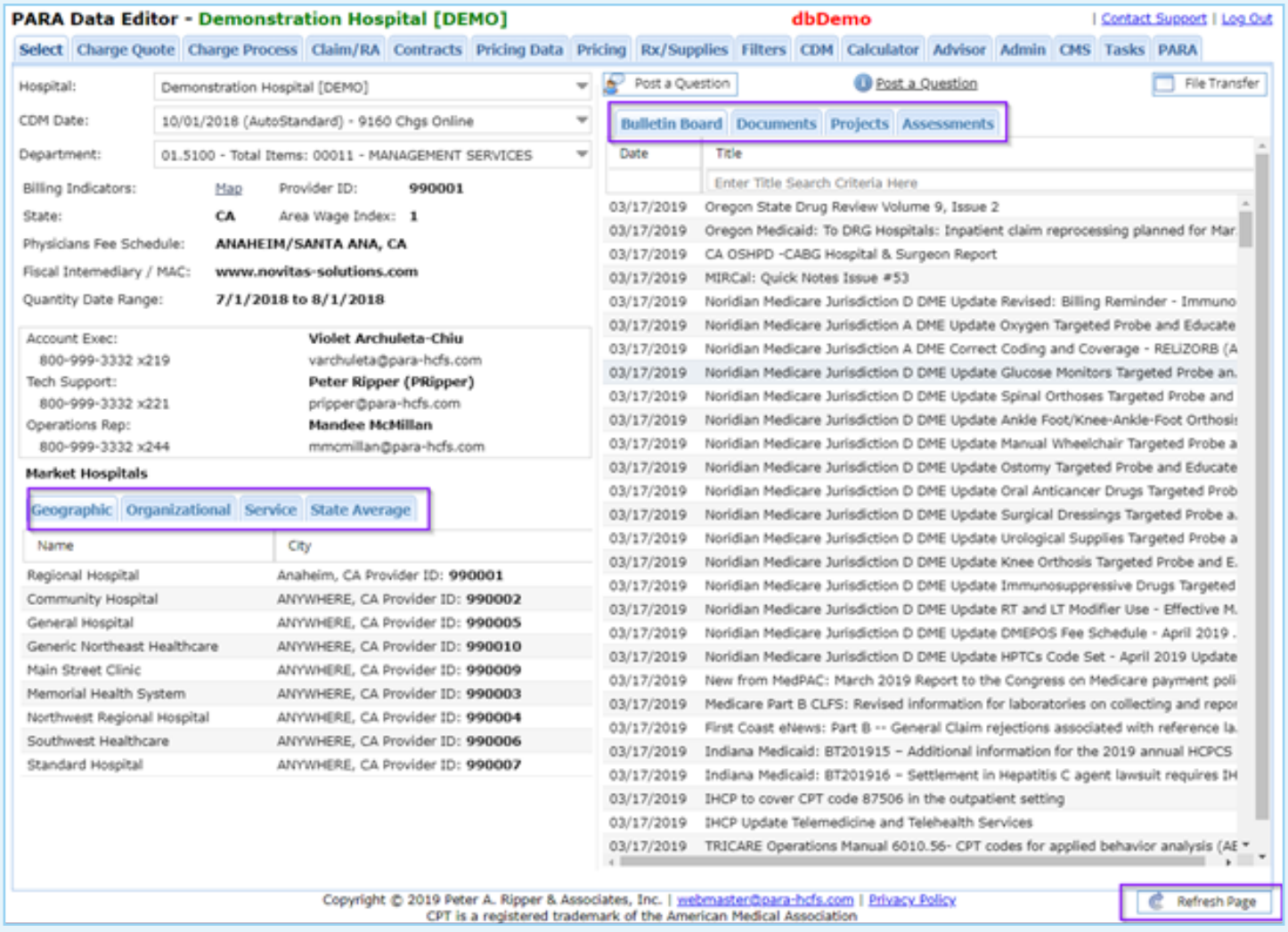
CMS Medicare Learning Network

**Download your copy of this Fact Sheet by clicking on the photo to the left.**

# PARA DATA EDITOR UPGRADE


On April 1, 2019 the Multiple Browser compatible version of the **PARA Data Editor (PDE)** will go live and the current version will be removed. The new version can be accessed with Internet Explorer or Chrome with no changes to the User's experience. There will be no need to update your bookmarks or favorites, the transition will be seamless. For those of you already using the Beta version compatible with the Chrome browser, you should notice very little difference.

The look and feel of the **PDE** will be slightly different, but the layout and functionality remain the same. There will also be some enhancements-in the image below, the market groups are now displayed by tab, rather than a drop-down menu-Projects and Assessments are available for viewing in addition to the Bulletin Board and Documents, and there is a "Refresh Page" button on each module:




If you have any questions regarding the new and improved **PDE**, please contact your Account Executive or Technical Support staff listed on the **Select** tab for your facility.

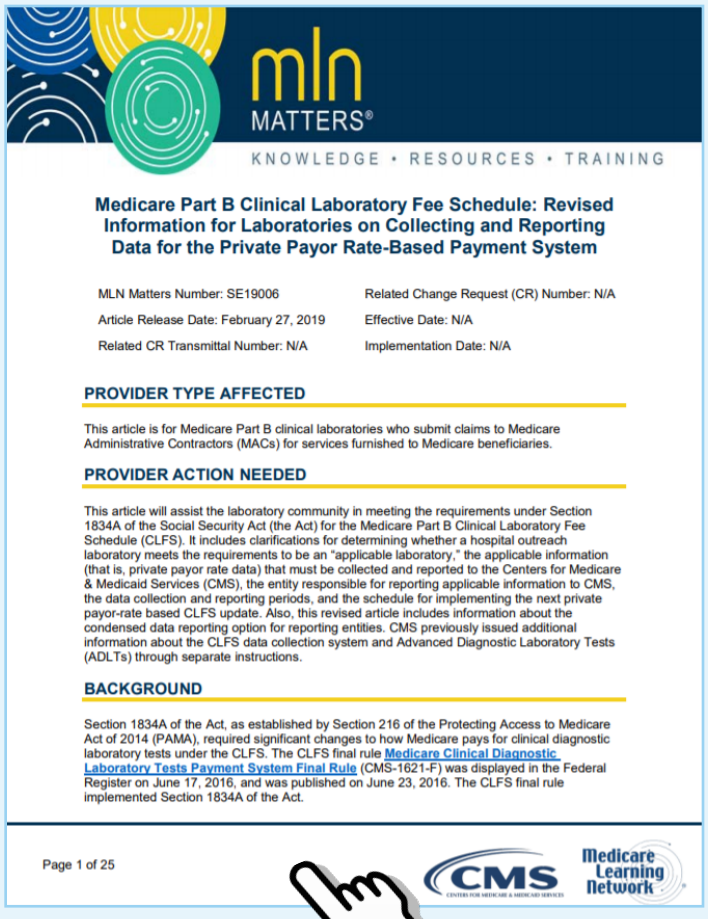
# CMS EXPANDS PRIVATE PAYOR LAB REIMBURSEMENT REPORTING

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

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

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

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



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

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

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

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

**PROVIDER TYPE AFFECTED**

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

**PROVIDER ACTION NEEDED**

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

**BACKGROUND**

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

Page 1 of 25

CMS Medicare Learning Network

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

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

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

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

## CMS EXPANDS PRIVATE PAYOR LAB REIMBURSEMENT REPORTING

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

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

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

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

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

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

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

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

## CMS EXPANDS PRIVATE PAYOR LAB REIMBURSEMENT REPORTING

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

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

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

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

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

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

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

**Revisions to the Definition of Applicable Laboratory**

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

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

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

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

# CMS EXPANDS PRIVATE PAYOR LAB REIMBURSEMENT REPORTING

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

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

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

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

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

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

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

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

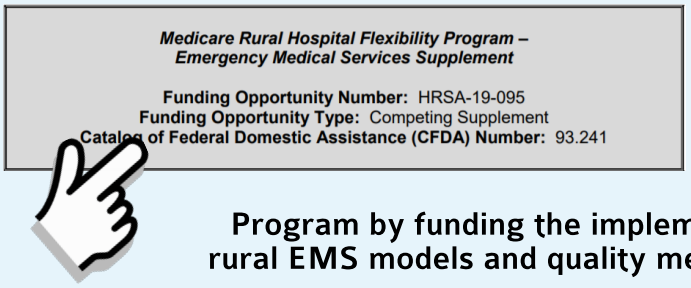
# RURAL HOSPITAL PROGRAM GRANTS AVAILABLE

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

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

## 340B Drug Pricing Program

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

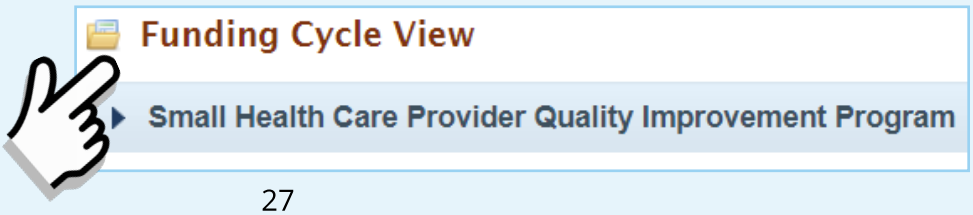




## Medicare Rural Hospital Flexibility Program - Emergency Medical Service Supplement

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

## Small Healthcare Provider Quality Improvement Program

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

# MLN CONNECTS

**PARA** invites you to check out the **mlnconnects** page available from the Centers For Medicare and Medicaid (CMS). It's chock full of news and information, training opportunities, events and more! Each week **PARA** will bring you the latest news and links to available resources. **Click each link for the PDF!**


**Thursday, March 21, 2019**

**News & Announcements**

· Hospice Provider Preview Reports: Review Your Data by March 31
· LTCH Provider Preview Reports: Review Your Data by April 3
· IRF Provider Preview Reports: Review Your Data by April 3
· Draft 2020 QRDA Category I Implementation Guide — Submit Comments by April 8
· Medicare Promoting Interoperability Program: Submit a Measure Proposal by June 28
· Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
· Influenza Activity Continues: Are Your Patients Protected?

**Compliance**

· Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

**Events**

· Submitting Your Medicare Part A Cost Report Electronically Webcast — March 28

**MLN Matters® Articles**

· I/OCE Specifications: April 2019 Update
· RARC, CARC, MREP and PC Print Update
· Active Billing Hospice Submitting Revocations — Revised
· Next Generation Sequencing NCD — Revised
· SNF Patient Driven Payment Model — Revised

**Publications**

· Inpatient Rehabilitation Facility Prospective Payment System — Revised
· Medicare Enrollment for Institutional Providers — Revised
· Medicare Enrollment Resources — Revised
· Items and Services Not Covered Under Medicare — Reminder

**Multimedia**

· Promoting Interoperability Listening Session: Audio Recording and Transcript

View this edition as a PDF

# WEEKLY IT UPDATE

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

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


## March 22, 2019 Update

| Week Ending | Platform | Tab | Enhancement | User Action |
|---|---|---|---|---|
| March 22nd, 2019 | Multi-Browser/IE | Calculator | HCPCS query for April 1st rates will be availabe on that day. Updated OPPS Addendum B, HCPCS and CPT codes will be available. | Users can query April 2019 reimbursement rates using the HCPCS query. |
| March 22nd, 2019 | Multi-Browser/IE | Calculator | April 2019 ASC Fee Schedule has been loaded into the PDE Calculator. | Users can view current ASC fee schedule information using the ASC reimbursement query on the PDE Calculator. |

## Previous Updates

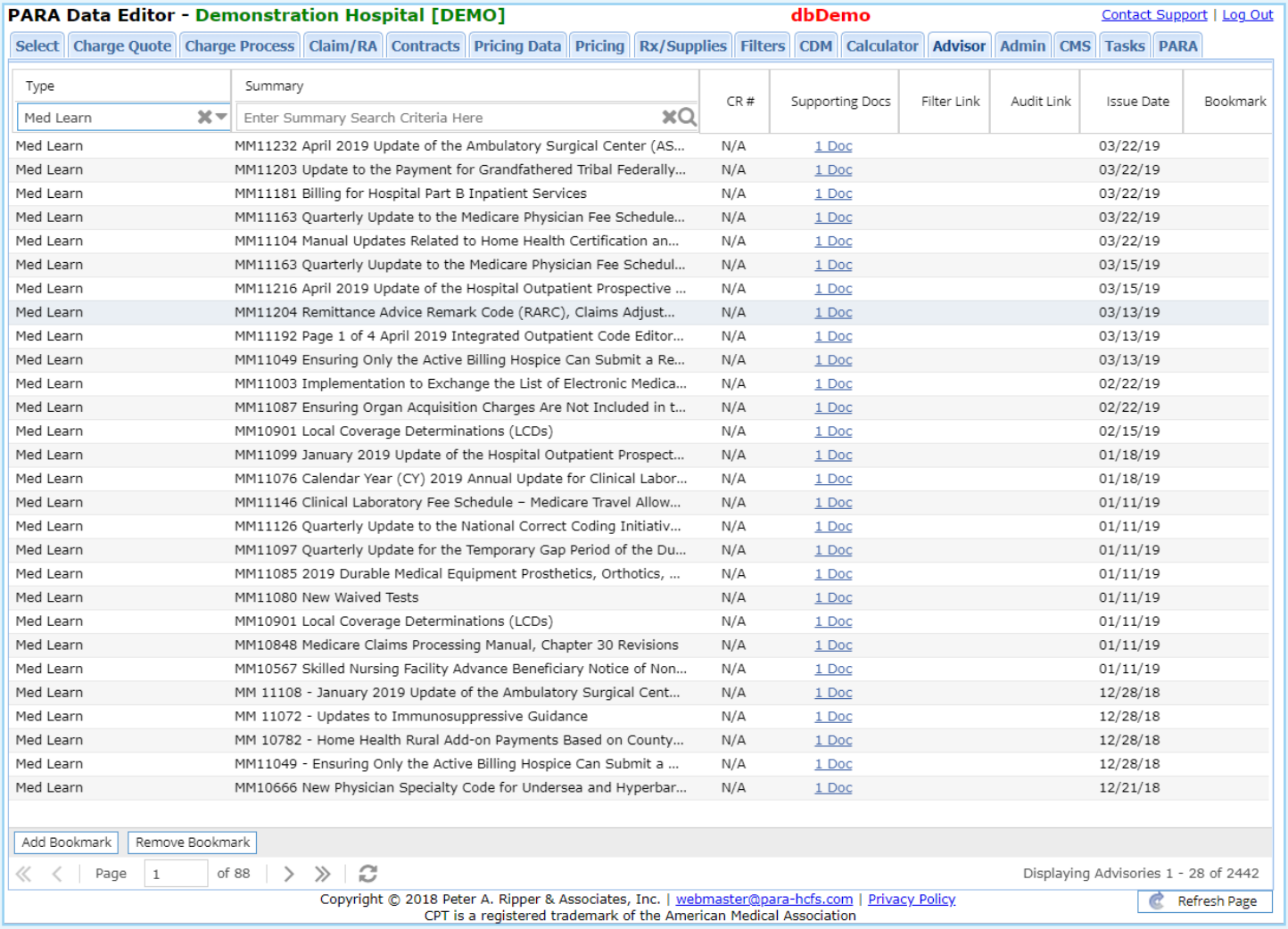
| Week Ending | Platform | Tab | Enhancement | User Action |
|---|---|---|---|---|
| March 15th, 2019 | Multi-Browser/IE | Calculator | April 2019 Medicaid NCCI Edits have been loaded into the PDE Calculator. | Users can view this information using the CCI Edits Medicaid query on the PDE Calculator. |
| March 15th, 2019 | Multi-Browser/IE | Calculator | April 2019 DME Fee Schedule has been loaded into the PDE Calculator. | Users can view current DME fee schedule information using the DME reimbursement query on the PDE Calculator. |
| March 15th, 2019 | Multi-Browser/IE | Calculator | April 2019 Physician Fee Schedule and RVU data from CMS has been loaded into the PDE Calculator. | Users can view current Physician fee schedule and RVU information using the Professional Fees query on the PDE Calculator. |

MLN Matters®
Official Information Health Care Professionals Can Trust

There were FIVE new or revised Med Learn (MLN Matters) articles released this week.

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

**FIND** ALL THESE MED LEARNS IN THE **ADVISOR** TAB OF THE **PDE** 5



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

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

| Type | Summary | CR # | Supporting Docs | Filter Link | Audit Link | Issue Date | Bookmark |
|---|---|---|---|---|---|---|---|
| Med Learn | Enter Summary Search Criteria Here | | | | | | |
| Med Learn | MM11232 April 2019 Update of the Ambulatory Surgical Center (AS... | N/A | 1 Doc | | | 03/22/19 | |
| Med Learn | MM11203 Update to the Payment for Grandfathered Tribal Federally... | N/A | 1 Doc | | | 03/22/19 | |
| Med Learn | MM11181 Billing for Hospital Part B Inpatient Services | N/A | 1 Doc | | | 03/22/19 | |
| Med Learn | MM11163 Quarterly Update to the Medicare Physician Fee Schedule... | N/A | 1 Doc | | | 03/22/19 | |
| Med Learn | MM11104 Manual Updates Related to Home Health Certification an... | N/A | 1 Doc | | | 03/22/19 | |
| Med Learn | MM11163 Quarterly Uupdate to the Medicare Physician Fee Schedul... | N/A | 1 Doc | | | 03/15/19 | |
| Med Learn | MM11216 April 2019 Update of the Hospital Outpatient Prospective ... | N/A | 1 Doc | | | 03/15/19 | |
| Med Learn | MM11204 Remittance Advice Remark Code (RARC), Claims Adjust... | N/A | 1 Doc | | | 03/13/19 | |
| Med Learn | MM11192 Page 1 of 4 April 2019 Integrated Outpatient Code Editor... | N/A | 1 Doc | | | 03/13/19 | |
| Med Learn | MM11049 Ensuring Only the Active Billing Hospice Can Submit a Re... | N/A | 1 Doc | | | 03/13/19 | |
| Med Learn | MM11003 Implementation to Exchange the List of Electronic Medica... | N/A | 1 Doc | | | 02/22/19 | |
| Med Learn | MM11087 Ensuring Organ Acquisition Charges Are Not Included in t... | N/A | 1 Doc | | | 02/22/19 | |
| Med Learn | MM10901 Local Coverage Determinations (LCDs) | N/A | 1 Doc | | | 02/15/19 | |
| Med Learn | MM11099 January 2019 Update of the Hospital Outpatient Prospect... | N/A | 1 Doc | | | 01/18/19 | |
| Med Learn | MM11076 Calendar Year (CY) 2019 Annual Update for Clinical Labor... | N/A | 1 Doc | | | 01/18/19 | |
| Med Learn | MM11146 Clinical Laboratory Fee Schedule – Medicare Travel Allow... | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM11126 Quarterly Update to the National Correct Coding Initiativ... | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM11097 Quarterly Update for the Temporary Gap Period of the Du... | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM11085 2019 Durable Medical Equipment Prosthetics, Orthotics, ... | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM11080 New Waived Tests | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM10901 Local Coverage Determinations (LCDs) | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM10848 Medicare Claims Processing Manual, Chapter 30 Revisions | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM10567 Skilled Nursing Facility Advance Beneficiary Notice of Non... | N/A | 1 Doc | | | 01/11/19 | |
| Med Learn | MM 11108 - January 2019 Update of the Ambulatory Surgical Cent... | N/A | 1 Doc | | | 12/28/18 | |
| Med Learn | MM 11072 - Updates to Immunosuppressive Guidance | N/A | 1 Doc | | | 12/28/18 | |
| Med Learn | MM 10782 - Home Health Rural Add-on Payments Based on County... | N/A | 1 Doc | | | 12/28/18 | |
| Med Learn | MM11049 - Ensuring Only the Active Billing Hospice Can Submit a ... | N/A | 1 Doc | | | 12/28/18 | |
| Med Learn | MM10666 New Physician Specialty Code for Undersea and Hyperbar... | N/A | 1 Doc | | | 12/21/18 | |

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# Manual Updates Related to Home Health Certification and Recertification Policy Changes

MLN Matters Number: MM11104

Related Change Request (CR) Number: CR 11104

Related CR Release Date: March 22, 2019

Effective Date: April 22, 2019

Related CR Transmittal Number: R258BP and R870PI

Implementation Date: April 22, 2019

## PROVIDER TYPE AFFECTED

This MLN Matters Article is for physicians and Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for Home Health Services provided to Medicare beneficiaries.

## PROVIDER ACTION NEEDED

CR11104 updates the Medicare Benefit Policy Manual and Medicare Program Integrity Manual to reflect policy changes in recertification for home health services that the Centers for Medicare & Medicaid Services (CMS) finalized in the Calendar Year (CY) 2019 Home Health Prospective Payment System (HH PPS) final rule (83 FR 56406).

CR11104 also updates the Medicare Benefit Policy Manual to clarify the home health plan of care requirements for payment as a result of the recent changes to the home health plan of care requirements in the Medicare Conditions of Participation (CoPs) finalized in the January 13, 2017 Conditions of Participation for Home Health Agencies final rule (82 FR 4504).

## BACKGROUND

**Update to the Recertification Requirements**

The Code of Federal Regulations (CFR) at 42 CFR 424.22(b)(2) provides the requirements for home health services recertification. Currently, the regulations require the certifying physician to include a statement that:

1) Indicates the continuing need for services; and
2) Estimates how much longer the beneficiary will require home health services.

CMS finalized a change to these physician recertification requirements in the CY 2019 HH PPS final rule (83 FR 56524). Specifically, this rule eliminates the requirement that the certifying



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# July 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM11225 | Related Change Request (CR) Number: 11225

Related CR Release Date: March 22, 2019 | Effective Date: July 1, 2019

Related CR Transmittal Number: R4264CP | Implementation Date: July 1, 2019

## PROVIDER TYPE 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 11225 provides the quarterly update for Average Sales Price (ASP) and ASP Not Otherwise Classified (NOC) Medicare Part B Drug Pricing Files and Revisions to the prior quarterly pricing files. CR11225 instructs MACs to download and implement the July 2019 and, if released, the revised April 2019, January 2019, October 2018, and July 2018 files. Make sure your billing staffs are aware of these updates.

Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in chapter 4, section 50 of the Medicare Claims Processing Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf. Make sure that your billing staffs are aware of these changes.

## BACKGROUND

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply the MACs with the ASP and ASP NOC drug pricing files for Medicare Part B drugs on a quarterly basis. CR 11225 addresses the following pricing files:

- File: July 2019 ASP and ASP NOC -- Effective Dates of Service: July 1, 2019, through September 30, 2019



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# Billing for Hospital Part B Inpatient Services

MLN Matters Number: MM11181 | Related Change Request (CR) Number: 11181

Related CR Release Date: March 22, 2019 | Effective Date: October 1, 2013

Related CR Transmittal Number: R4259CP | Implementation Date: June 29, 2019

## PROVIDER TYPE AFFECTED

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

## PROVIDER ACTION NEEDED

CR11181 provides billing instructions for hospital Part B inpatient services. Make sure your billing staffs are aware if these instructions.

## BACKGROUND

Medicare pays for hospital, including Critical Access Hospital (CAH), inpatient Part B services in the circumstances provided in the Medicare Benefit Policy Manual, Chapter 6, Section 10 (Medical and Other Health Services Furnished to Inpatients of Participating Hospitals). Hospitals must bill Part B inpatient services on a 12x Type of Bill. This Part B inpatient claim is subject to the statutory time limit for filing Part B claims described in the Medicare Claims Processing Manual, Chapter 1, Section 70.

A hospital may bill for Part B inpatient services if the hospital determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the hospital already discharged the beneficiary from the hospital (commonly referred to as hospital self-audit). If the hospital already submitted a claim to Medicare for payment under Part A, the hospital must cancel its Part A claim prior to submitting a claim for payment of Part B inpatient services.

Whether or not the hospital submitted a claim to Part A for payment, Medicare requires the hospital to submit a Part A claim indicating that the provider is liable under Section 1879 of the Social Security Act for the cost of the Part A services. The hospital could then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the hospital treated the beneficiary as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.



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# Update to the Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) for Calendar Year (CY) 2019

MLN Matters Number: MM11203
Related CR Release Date: March 22, 2019
Related CR Transmittal Number: R4261CP

Related Change Request (CR) Number: CR 11203
Effective Date: July 1, 2019
Implementation Date: July 1, 2019

## PROVIDER TYPE AFFECTED

This MLN Matters Article is for Federally Qualified Health Centers (FQHCs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

## WHAT YOU NEED TO KNOW

CR 11203 updates the Federally Qualified Health Center Prospective Payment System (FQHC PPS) grandfathered tribal FQHC base payment rate.

## BACKGROUND

### Payment for FQHCs under the PPS

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111–148 and Pub. L. 111–152) added section 1834(o) of the Social Security Act (the Act) to establish a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates. In the PPS for FQHC Final Rule published in the May 2, 2014, Federal Register (79 FR 25436), the Centers for Medicare & Medicaid Services (CMS) implemented a methodology and payment rates for FQHCs under the PPS beginning on October 1, 2014.

### Payment for Grandfathered Tribal FQHCs That Were Provider-Based Clinics on or Before April 7, 2000

Effective for dates of service on or after January 1, 2016, Indian Health Services (IHS) and tribal facilities and organizations that met the conditions of 42 CFR section 413.65(m) on or before April 7, 2000, and have a change in their status on or after April 7, 2000 from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another



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# April 2019 Update of the Ambulatory Surgical Center (ASC) Payment System

MLN Matters Number: MM11232
Related Change Request (CR) Number: 11232
Related CR Release Date: March 22, 2019
Effective Date: April 1, 2019
Related CR Transmittal Number: R4263CP
Implementation Date: April 1, 2019

## PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services subject to the Ambulatory Surgical Center (ASC) payment system and provided to Medicare beneficiaries.

## PROVIDER ACTION NEEDED

CR11232 describes changes to and billing instructions for various payment policies implemented in the April 2019 ASC payment system update. The CR also includes HCPCS updates. Please make sure your billing staffs are aware of these changes.

## BACKGROUND

This article includes Calendar Year (CY) 2019 payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG) files. The Centers for Medicare & Medicaid Services (CMS) is also including an April 2019 ASC Payment Indicator (ASC PI) file. CMS is not issuing April 2019 ASC Fee Schedule (ASCFS) and ASC Code Pair files in CR11232. The changes are as follows:

**1. Drugs and Biologicals**

**a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2019**

For CY 2019, payment for non-pass-through drugs and biologicals continues to be made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. Also, in CY 2019, a single payment of ASP + 6 percent continues for Outpatient Prospective Payment System (OPPS)



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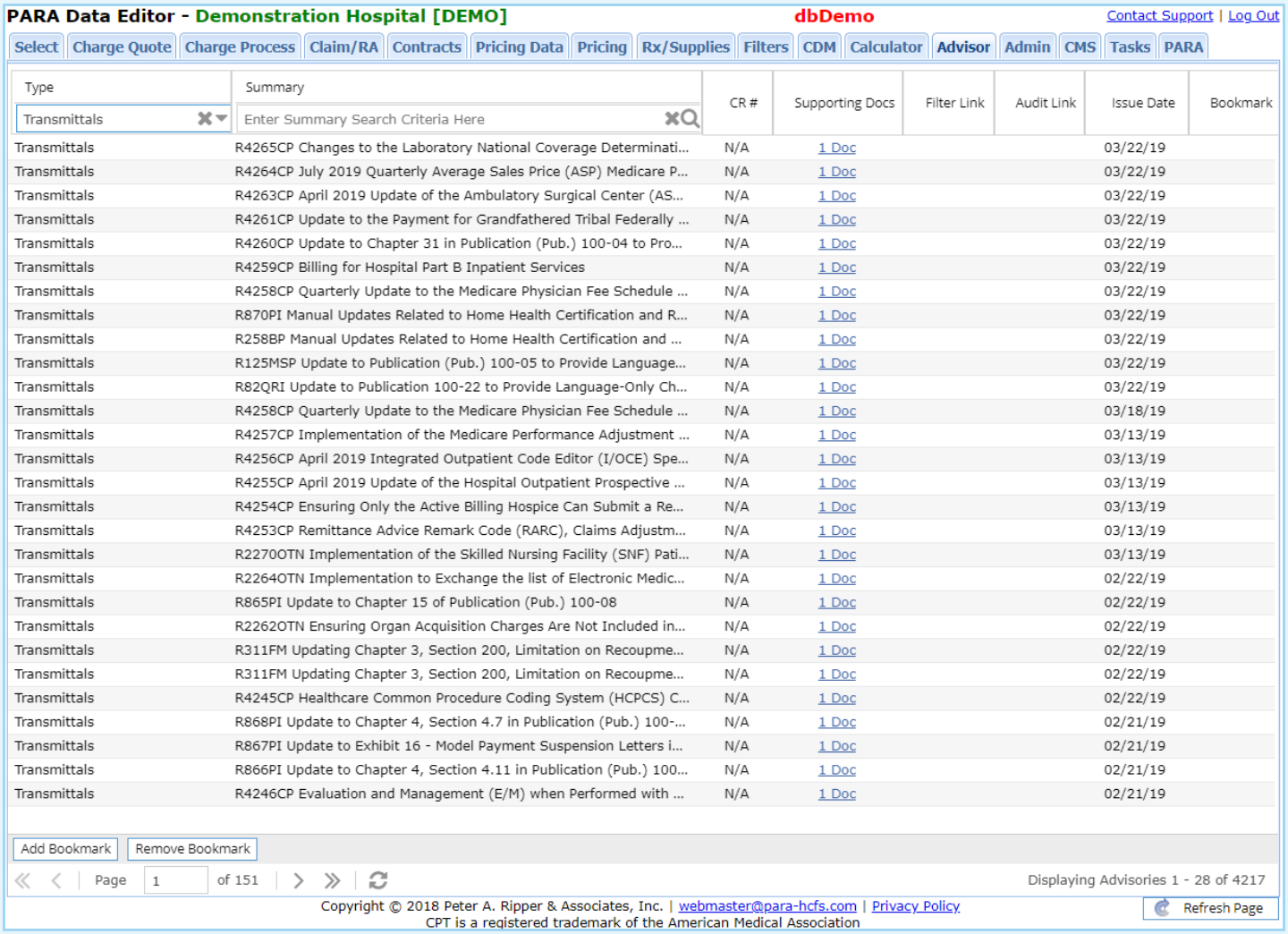

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| Transmittals | R4265CP Changes to the Laboratory National Coverage Determinati... | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R4264CP July 2019 Quarterly Average Sales Price (ASP) Medicare P... | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R4263CP April 2019 Update of the Ambulatory Surgical Center (AS... | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R4261CP Update to the Payment for Grandfathered Tribal Federally ... | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R4260CP Update to Chapter 31 in Publication (Pub.) 100-04 to Pro... | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R4259CP Billing for Hospital Part B Inpatient Services | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R4258CP Quarterly Update to the Medicare Physician Fee Schedule ... | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R870PI Manual Updates Related to Home Health Certification and R... | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R258BP Manual Updates Related to Home Health Certification and ... | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R125MSP Update to Publication (Pub.) 100-05 to Provide Language... | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R82QRI Update to Publication 100-22 to Provide Language-Only Ch... | N/A | 1 Doc | | | 03/22/19 | |
| Transmittals | R4258CP Quarterly Update to the Medicare Physician Fee Schedule ... | N/A | 1 Doc | | | 03/18/19 | |
| Transmittals | R4257CP Implementation of the Medicare Performance Adjustment ... | N/A | 1 Doc | | | 03/13/19 | |
| Transmittals | R4256CP April 2019 Integrated Outpatient Code Editor (I/OCE) Spe... | N/A | 1 Doc | | | 03/13/19 | |
| Transmittals | R4255CP April 2019 Update of the Hospital Outpatient Prospective ... | N/A | 1 Doc | | | 03/13/19 | |
| Transmittals | R4254CP Ensuring Only the Active Billing Hospice Can Submit a Re... | N/A | 1 Doc | | | 03/13/19 | |
| Transmittals | R4253CP Remittance Advice Remark Code (RARC), Claims Adjustm... | N/A | 1 Doc | | | 03/13/19 | |
| Transmittals | R2270OTN Implementation of the Skilled Nursing Facility (SNF) Pati... | N/A | 1 Doc | | | 03/13/19 | |
| Transmittals | R2264OTN Implementation to Exchange the list of Electronic Medic... | N/A | 1 Doc | | | 02/22/19 | |
| Transmittals | R865PI Update to Chapter 15 of Publication (Pub.) 100-08 | N/A | 1 Doc | | | 02/22/19 | |
| Transmittals | R2262OTN Ensuring Organ Acquisition Charges Are Not Included in... | N/A | 1 Doc | | | 02/22/19 | |
| Transmittals | R311FM Updating Chapter 3, Section 200, Limitation on Recoupme... | N/A | 1 Doc | | | 02/22/19 | |
| Transmittals | R311FM Updating Chapter 3, Section 200, Limitation on Recoupme... | N/A | 1 Doc | | | 02/22/19 | |
| Transmittals | R4245CP Healthcare Common Procedure Coding System (HCPCS) C... | N/A | 1 Doc | | | 02/22/19 | |
| Transmittals | R868PI Update to Chapter 4, Section 4.7 in Publication (Pub.) 100-... | N/A | 1 Doc | | | 02/21/19 | |
| Transmittals | R867PI Update to Exhibit 16 - Model Payment Suspension Letters i... | N/A | 1 Doc | | | 02/21/19 | |
| Transmittals | R866PI Update to Chapter 4, Section 4.11 in Publication (Pub.) 100... | N/A | 1 Doc | | | 02/21/19 | |
| Transmittals | R4246CP Evaluation and Management (E/M) when Performed with ... | N/A | 1 Doc | | | 02/21/19 | |

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| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-22 Medicare Quality Reporting Incentive Programs | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 82** | **Date: March 22, 2019** |
| | **Change Request 11166** |

**SUBJECT: Update to Publication 100-22 to Provide Language-Only Changes for the New Medicare Card Project**

**I. SUMMARY OF CHANGES:** This Change Request (CR) contains language-only changes for updating the New Medicare Card Project-related language in Publication 100-22. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

**EFFECTIVE DATE: April 22, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: April 22, 2019**

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**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
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| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 1/50.1.1/Coding and Reporting Principles for Claims-based Reporting |

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

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

**The link to this Transmittal R125MSP**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-05 Medicare Secondary Payer | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 125** | **Date: March 22, 2019** |
| | **Change Request 11193** |

**SUBJECT: Update to Publication (Pub.) 100-05 to Provide Language-Only Changes for the New Medicare Card Project**

**I. SUMMARY OF CHANGES:** This Change Request (CR) contains language-only changes for updating the New Medicare Card Project-related language in Pub 100-05. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

**EFFECTIVE DATE: April 22, 2019**
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**IMPLEMENTATION DATE: April 22, 2019**

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**The link to this Transmittal R258BP**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-02 Medicare Benefit Policy | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 258 | Date: March 22, 2019 |
| | Change Request 11104 |

**SUBJECT: Manual Updates Related to Home Health Certification and Recertification Policy Changes**

**I. SUMMARY OF CHANGES:** This Change Request (CR) updates the Medicare Benefit Policy Manual, (Pub. 100-02), Chapter 7 and the Medicare Program Integrity Manual (Pub. 100-08), Chapter 6, to reflect policy changes finalized in the CY 2019 Home Health Prospective Payment System (HH PPS) Final Rule (83 FR 56406), related to recertification for home health services. This CR also updates the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 7, to reflect Condition of Participation changes finalized in the Medicare Home Health Conditions of Participation Final Rule (82 FR 4504).

**EFFECTIVE DATE: April 22, 2019**
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**IMPLEMENTATION DATE: April 22, 2019**

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| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 7/30.2.1/Content of the Plan of Care |
| R | 7/30.5.2/Physician Recertification |

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

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

**The link to this Transmittal R870PI**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 870** | **Date: March 22, 2019** |
| | **Change Request 11104** |

**SUBJECT: Manual Updates Related to Home Health Certification and Recertification Policy Changes**

**I. SUMMARY OF CHANGES:** This Change Request (CR) updates the Medicare Benefit Policy Manual, (Pub. 100-02), Chapter 7 and the Medicare Program Integrity Manual (Pub. 100-08), Chapter 6, to reflect policy changes finalized in the CY 2019 Home Health Prospective Payment System (HH PPS) Final Rule (83 FR 56406), related to recertification for home health services. This CR also updates the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 7, to reflect Condition of Participation changes finalized in the Medicare Home Health Conditions of Participation Final Rule (82 FR 4504).

**EFFECTIVE DATE: April 22, 2019**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: April 22, 2019**

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|---|---|
| R | 6/6.2.2.1/Recertification Elements |

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

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

**The link to this Transmittal R4259CP**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 4259** | **Date: March 22, 2019** |
| | **Change Request 11181** |

**SUBJECT: Billing for Hospital Part B Inpatient Services**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to provide billing instructions for hospital Part B inpatient services.

**EFFECTIVE DATE: October 1, 2013**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: June 21, 2019**

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| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 4/240.1/ Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials |
| R | 4/240.2/ Editing Of Hospital Part B Inpatient Services: Other Circumstances in Which Payment Cannot Be Made under Part A |

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

**Business Requirements**
**Manual Instruction**

**The link to this Transmittal R4260CP**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 4260** | **Date: March 22, 2019** |
| | **Change Request 11178** |

**SUBJECT: Update to Chapter 31 in Publication (Pub.) 100-04 to Provide Language-Only Changes for the New Medicare Card Project**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update Chapter 31 in Pub. 100-04 with the New Medicare Card Project-related language. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

**EFFECTIVE DATE: April 22, 2019**
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**IMPLEMENTATION DATE: April 22, 2019**

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|---|---|
| R | 31/20/20.1.2/Online Direct Data Entry (DDE) |

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

**Business Requirements**
**Manual Instruction**

**The link to this Transmittal R4261CP**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 4261** | **Date: March 22, 2019** |
| | **Change Request 11203** |

**SUBJECT: Update to the Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) for Calendar Year (CY) 2019**

**I. SUMMARY OF CHANGES:** This Change Request (CR) updates the Federally Qualified Health Center Prospective Payment System (FQHC PPS) grandfathered tribal FQHC base payment rate.

The initial release of this Recurring Update Notification applies to Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111–148 and Pub. L. 111–152).

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

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

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

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

**III. FUNDING:**
**For Medicare Administrative Contractors (MACs):**
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 R4263CP**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 4263** | **Date: March 22, 2019** |
| | **Change Request 11232** |

**SUBJECT: April 2019 Update of the Ambulatory Surgical Center (ASC) Payment System**

**I. SUMMARY OF CHANGES:** This recurring update notification describes changes to and billing instructions for various payment policies implemented in the April 2019 ASC payment system update. This recurring update notification applies to publication 100-04, chapter 14 of the Internet-Only Manual (IOM). As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

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

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

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**IV. ATTACHMENTS:**

**Recurring Update Notification**

**The link to this Transmittal R4264CP**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 4264** | **Date: March 22, 2019** |
| | **Change Request 11225** |

**SUBJECT: July 2019 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 IOM.

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

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|---|---|
| N/A | N/A |

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**IV. ATTACHMENTS:**

**Recurring Update Notification**

**The link to this Transmittal R4265CP**

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 4265** | **Date: March 22, 2019** |
| | **Change Request 11224** |

**SUBJECT: Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2019**

**I. SUMMARY OF CHANGES:** This Change Request (CR) announces the changes that will be included in the July 2019 quarterly release of the edit module for clinical diagnostic laboratory services. This Recurring Update Notification applies to Chapter 16, Section 120.2, Publication 100-04.

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

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

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| N/A | N/A |

**III. FUNDING:**

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**IV. ATTACHMENTS:**

**Recurring Update Notification**

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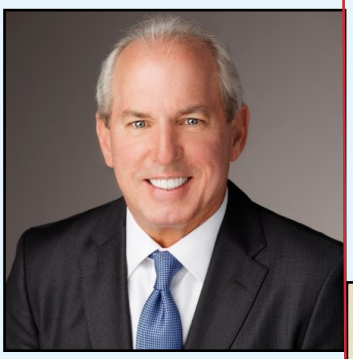

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*pripper*
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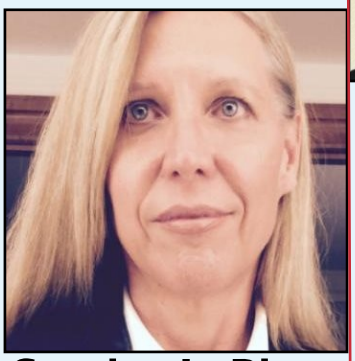

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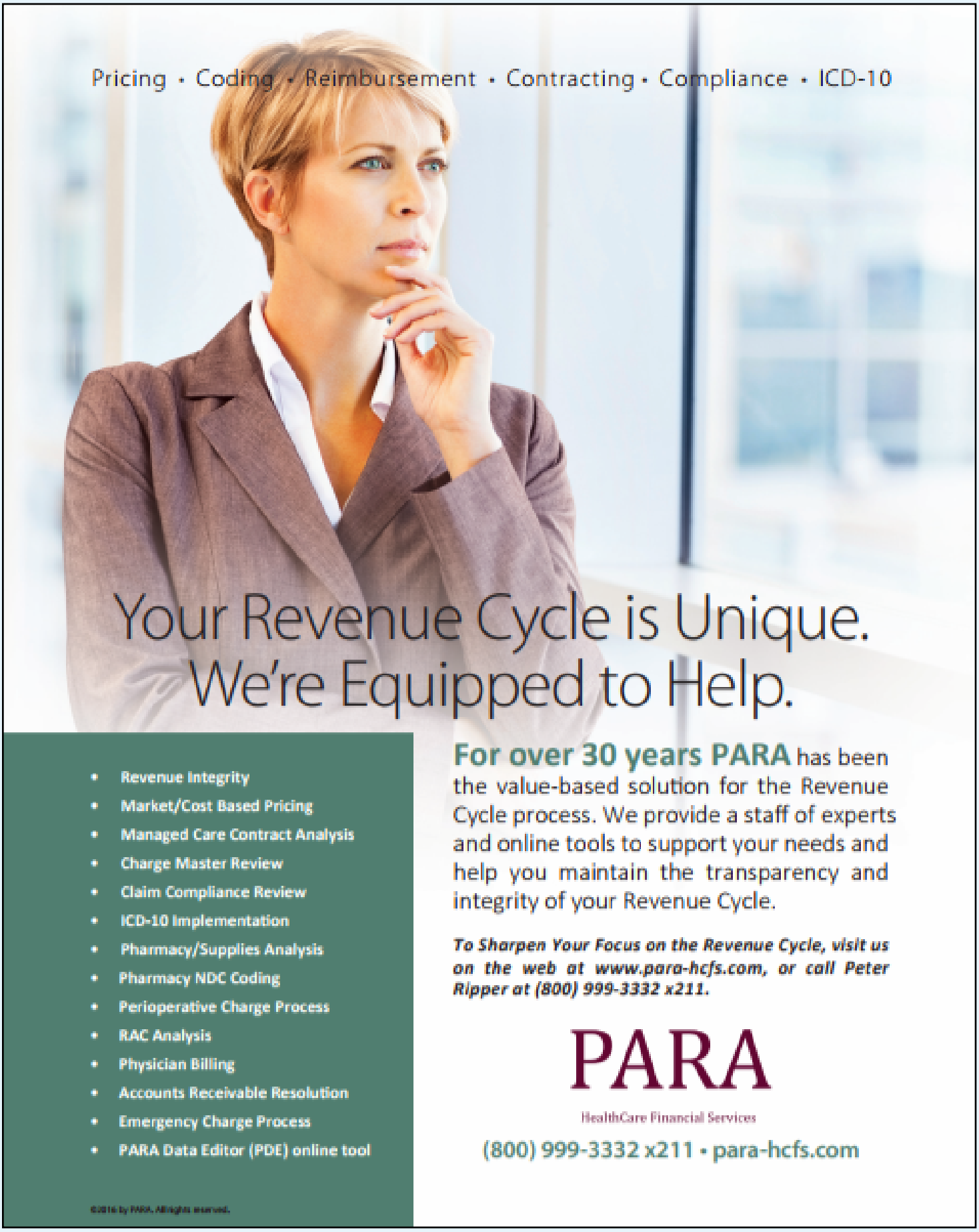
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