PARA HealthCare Analytics
HEALTHCARE FINANCIAL RESOURCES

May 20, 2020

PARA Weekly eJOURNAL

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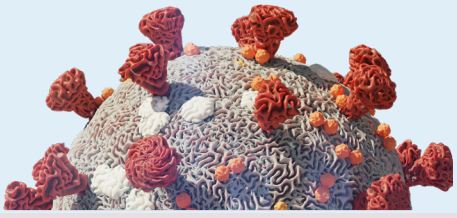

Additional Facility Pay For Professional Fees

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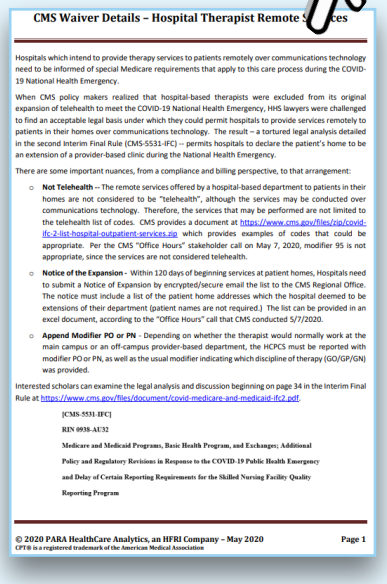
FAST LINKS

REHAB REMOTE SERVICES ON A HOSPITAL CLAIM

Q. Can you tell me more about how to bill remote services on a hospital claim?


CMS Waiver Details – Hospital Therapist Remote Services

Hospitals which intend to provide therapy services to patients remotely over communications technology need to be informed of special Medicare requirements that apply to this care process during the COVID-19 National Health Emergency.

When CMS policy makers realized that hospital-based therapists were excluded from its original expansion of telehealth to meet the COVID-19 National Health Emergency, HHS lawyers were challenged to find an acceptable legal basis under which they could permit hospitals to provide services remotely to patients in their homes over communications technology. The result – a tortured legal analysis detailed in the second Interim Final Rule (CMS-5531-IFC) -- permits hospitals to declare the patient's home to be an extension of a provider-based clinic during the National Health Emergency.

There are some important nuances, from a compliance and billing perspective, to that arrangement:

- **Not Telehealth** -- The remote services offered by a hospital-based department to patients in their homes are not considered to be "telehealth", although the services may be conducted over communications technology. Therefore, the services that may be performed are not limited to the telehealth list of codes. CMS provides a document at https://www.cms.gov/files/zip/covid-ifc-2-list-hospital-outpatient-services.zip which provides examples of codes that could be appropriate. Per the CMS "Office Hours" stakeholder call on May 7, 2020, modifier 95 is not appropriate, since the services are not considered telehealth.
- **Notice of the Expansion** - Within 120 days of beginning services at patient homes, Hospitals need to submit a Notice of Expansion by encrypted/secure email the list to the CMS Regional Office. The notice must include a list of the patient home addresses which the hospital deemed to be extensions of their department (patient names are not required.) The list can be provided in an excel document, according to the "Office Hours" call that CMS conducted 5/7/2020.
- **Append Modifier PO or PN** - Depending on whether the therapist would normally work at the main campus or an off-campus provider-based department, the HCPCS must be reported with modifier PO or PN, as well as the usual modifier indicating which discipline of therapy (GO/GP/GN) was provided.

Interested scholars can examine the legal analysis and discussion beginning on page 34 in the Interim Final Rule at https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf.

[CMS-5531-IFC]

RIN 0938-AU32

Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program

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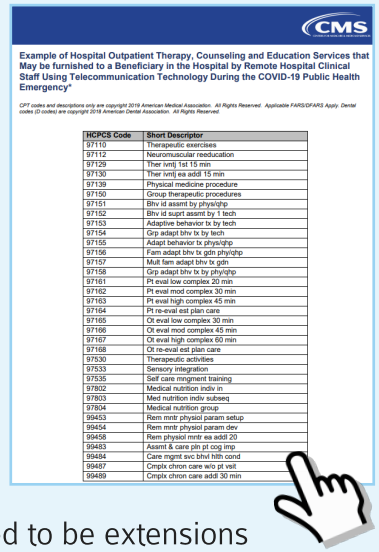
CPT® is a registered trademark of the American Medical Association

A. ANDSWER:On April 30, 2020, Medicare expanded the ability of hospital therapists to provide service remotely, over telecommunications, to patients during the COVID-19 National Health Emergency. While they made the announcement on April 30, 2020, it's taken us a few days to understand the billing and reporting requirements. the attached papers also offer more information.

When CMS realized that hospital-based therapists were excluded from the expansion of telehealth, it challenged Medicare's lawyers to find an acceptable legal basis under which they could permit hospital therapists to provide services remotely to patients in their homes over communications technology. The tortured theory CMS constructed permits hospitals to declare the patient's home to be an extension of a provider-based clinic during the National Health Emergency.


CMS

Example of Hospital Outpatient Therapy, Counseling and Education Services that May be furnished to a Beneficiary in the Hospital by Remote Hospital Clinical Staff Using Telecommunication Technology During the COVID-19 Public Health Emergency*

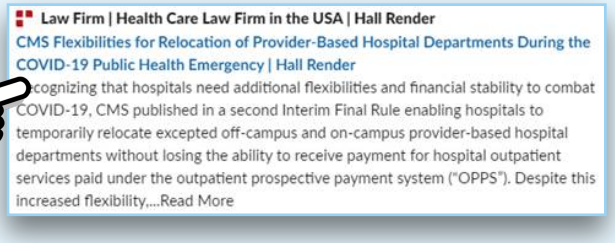
CPT codes and descriptions only are copyright 2019 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental codes (D codes) are copyright 2018 American Dental Association. All Rights Reserved.

HCPCS Code	Short Descriptor
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97129	Ther ivntj 1st 15 min
97130	Ther ivntj ea addl 15 min
97139	Physical medicine procedure
97150	Group therapeutic procedures
97151	Bhv id assmt by phys/qhp
97152	Bhv id supvt assmt by 1 tech
97153	Adaptive behavior tx by tech
97154	Grp adapt bhv tx by tech
97155	Adapt behavior tx phys/qhp
97156	Fam adapt bhv tx gdn phy/qhp
97157	Mult fam adapt bhv tx gdn
97158	Grp adapt bhv tx by phy/qhp
97161	Pt eval low complex 20 min
97162	Pt eval mod complex 30 min
97163	Pt eval high complex 45 min
97164	Pt re-eval est plan care
97165	Ot eval low complex 30 min
97166	Ot eval mod complex 45 min
97167	Ot eval high complex 60 min
97168	Ot re-eval est plan care
97530	Therapeutic activities
97533	Sensory integration
97535	Self care mngment training
97802	Medical nutrition indiv in
97803	Med nutrition indiv subseq
97804	Medical nutrition group
99453	Rem mntr physiol param setup
99454	Rem mntr physiol param dev
99458	Rem physiol mntr ea addl 20
99483	Asamt & care pln pt cog imp
99484	Care mgmt svc bhvl hlth cond
99487	Cmplx chron care w/o pt vsit
99489	Cmplx chron care addl 30 min

- The remote services offered by a hospital-based department to patients in their homes are not considered to be "telehealth", although the services may be conducted over communications technology. Therefore, the services that may be performed are not limited to the telehealth list of codes. In the attached CMS document, Medicare offers a list of codes that serve as examples of services they would expect to be appropriate. Per the CMS "Office Hours" stakeholder call on May 7, 2020, modifier 95 is not appropriate, since the services are not considered telehealth
- Within 120 days of beginning services at patient homes, Hospitals need to submit to CMS a list of the addresses which the hospital deemed to be extensions of their department. The list of addresses can be submitted all at once in an excel document, according to the "Office Hours" call that CMS conducted yesterday
- Depending on whether the therapist would normally work at the main campus or an off-campus provider-based department, the HCPCS must be reported with modifier PO or PN, as well as the usual modifier indicating which discipline of therapy (GO/GP/GN) was provided

Incidentally, there is also a good article explaining the requirements published by a reputable law firm at the link below:

https://www.hallrender.com/2020/05/07/cms-flexibilities-for-relocation-of-provider-based-hospital-departments-during-the-covid-19-public-health-emergency/


Law Firm | Health Care Law Firm in the USA | Hall Render

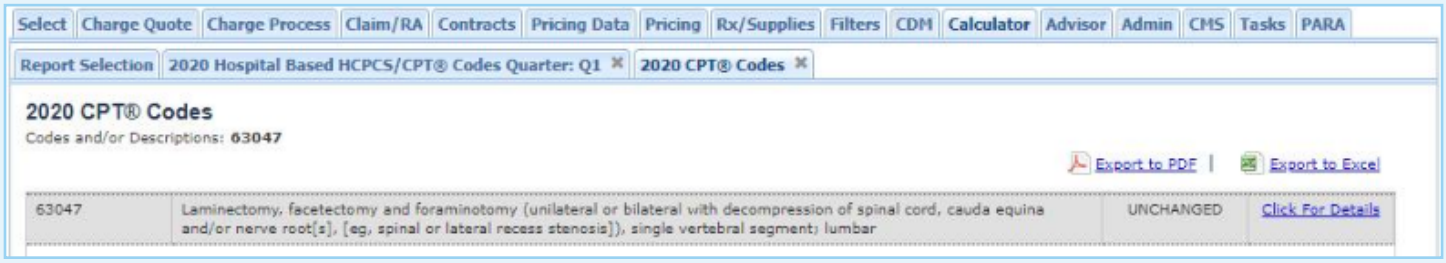
CMS Flexibilities for Relocation of Provider-Based Hospital Departments During the COVID-19 Public Health Emergency | Hall Render

Recognizing that hospitals need additional flexibilities and financial stability to combat COVID-19, CMS published in a second Interim Final Rule enabling hospitals to temporarily relocate excepted off-campus and on-campus provider-based hospital departments without losing the ability to receive payment for hospital outpatient services paid under the outpatient prospective payment system ("OPPS"). Despite this increased flexibility,...Read More

SPINAL STENOSIS

Q. Please provide the CPT®s for a Lumbar decompression L4 to L5 with dome L4 laminectomy and partial L5 laminectomies, bilateral L5 foraminotomies, and left L4-L5 discectomy significant spinal stenosis?

A. ANSWER: Report CPT® code 63047 based on the documentation. The provider states that there is significant stenosis at the L4-L5 level. CPT® code 63047 specifies laminectomy, facetectomy and foraminotomy with decompression of the spinal cord, cauda equina and/or nerve roots. The parenthetical in the code description states "eg spinal or lateral recess stenosis". Therefore, when spinal stenosis is treated at the lumbar level, code 63047 is appropriate. AMA CPT® Assistant, December 2012 Page: 13 states, "If a laminoforaminotomy (hemilaminectomy) is performed at C3-4 or L4-5, this specific scenario may be reported using code 63045 (cervical) or 63047 (lumbar) based on the diagnosis of spinal stenosis, as listed in the parenthetical note." Please refer to the **PARA Data Editor** code description and the **PARA Data Editor** reference AMA CPT® Assistant December 2012.



PARA Data Editor

AMA CPT® Assistant December 2012. If a laminoforaminotomy (hemilaminectomy) is performed at C3-4 or L4-5, this specific scenario may be reported using code 63045 (cervical) or 63047 (lumbar) based on the diagnosis of spinal stenosis, as listed in the parenthetical note. When ascertaining code choice, the diagnostic indication in the parenthetical note of spinal stenosis supersedes the listed work in the descriptor, such as noted in code 63020 (cervical) or 63030 (lumbar).

For example, code 63047 describes the work of a complete laminectomy with full bilateral facetectomies and foraminotomies, procedures that surgeons rarely perform for lumbar lateral recess stenosis without a fusion.

For lumbar stenosis in the lateral recess requiring decompression, surgeons will typically perform partial (medial) facetectomies and foraminotomies as a stand-alone procedure, with code 63047 chosen based on diagnosis listed in the parenthetical note. Therefore, although the partial (medial) facetectomy and foraminotomy are described in codes 63020 and 63030, codes 63045 and 63047 are reported based on the diagnosis of stenosis, as stated in the parenthetical text in the code descriptor.

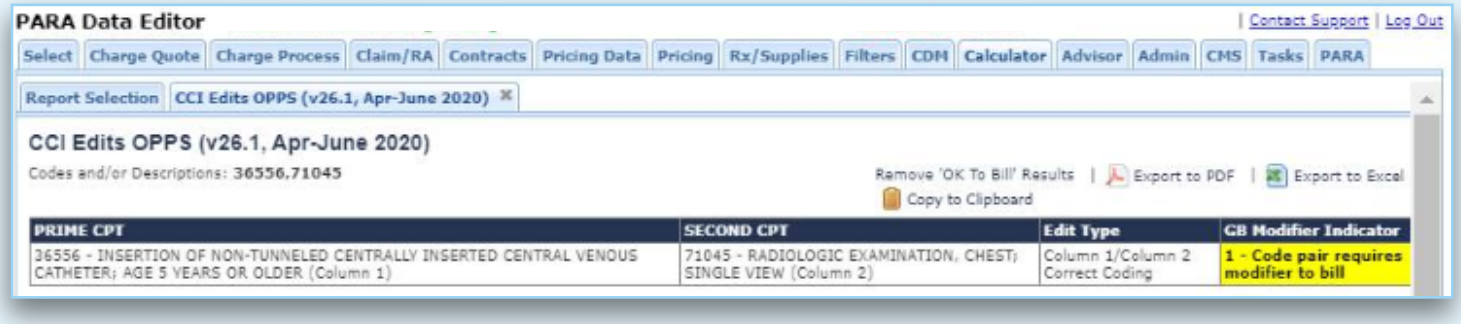
CHEST X-RAY

Q. We have received a letter from Humana stating that code pair 36556/71045 cannot be billed together. When reviewing the codes in the PDE system, and also through CMS we have found that the code pair does allow a modifier. We do have a modifier "XU" on the claim, but it appears that Humana would like to recoup their payment. Can **PARA** please review and provide feedback.

A. ANSWER: Report CPT® code 36566. CPT® code 71045 would not be separately reported. The documentation does not support separate and distinct services. The NCCI Manual states "When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax.

The chest radiologic examination is integral to the procedures, and the chest radiologic examination (e.g., CPT® codes 71045, 71046) shall not be reported separately".

Please refer to the **PARA Data Editor** CCI edits and the NCCI Manual Chapter 9.9 reference provided in the **PARA Data Editor.**



NCCI Manual 2020 Chapter 9.9

When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax. Similarly, when an emergency endotracheal intubation procedure (CPT® code 31500), chest tube insertion procedure (e.g., CPT® codes 32550, 32551, 32554, 32555), or insertion of a central flow directed catheter procedure (e.g., Swan-Ganz (CPT®code 93503)) is performed, a chest radiologic examination is usually performed to confirm the location and proper positioning of the tube or catheter.

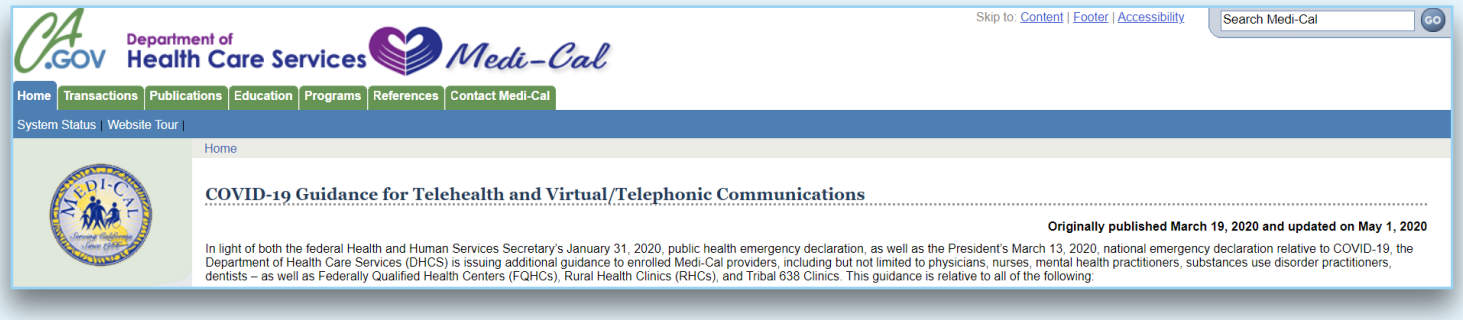
The chest radiologic examination is integral to the procedures, and the chest radiologic examination (e.g., CPT® codes 71045, 71046) shall not be reported separately.

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

In response to the public health declaration made on March 13, 2020, The California Department of Healthcare Services (DHCS) and Medi-Cal released a bulletin on May 15, 2020 issuing guidance to providers, including but not limited to physicians, nurses, mental health practitioners, substance use disorder practitioners, dentists, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Tribal 638 Clinics.

The guidance is pertinent to all participating providers to assist with providing medically necessary health care services for patients impacted by COVID-19.

http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_02.asp



The provisions for telehealth and COVID-19 include:

- Reiterating the flexibility allowed for delivery of covered Medi-Cal services via telehealth
- Ensuring beneficiaries have access to durable medical equipment (DME) and medical supplies
- Ensuring beneficiaries are not held financially responsible for any payment, including balance billing, for Medi-Cal covered services by providers, including testing and treatment for COVID-19
- Reviewing DHCS issued guidance on pharmacy services, Non-Emergency Medical Transportation and Non-Medical Transportation, as well as any other relevant guidance on DHCS website

Telehealth and Virtual Communication Options

Traditional Telehealth: Medi-Cal providers may utilize existing telehealth policies as an alternative modality for delivering covered health care services when medically appropriate. Highlights from the Medi-Cal provider manual on Telehealth include:

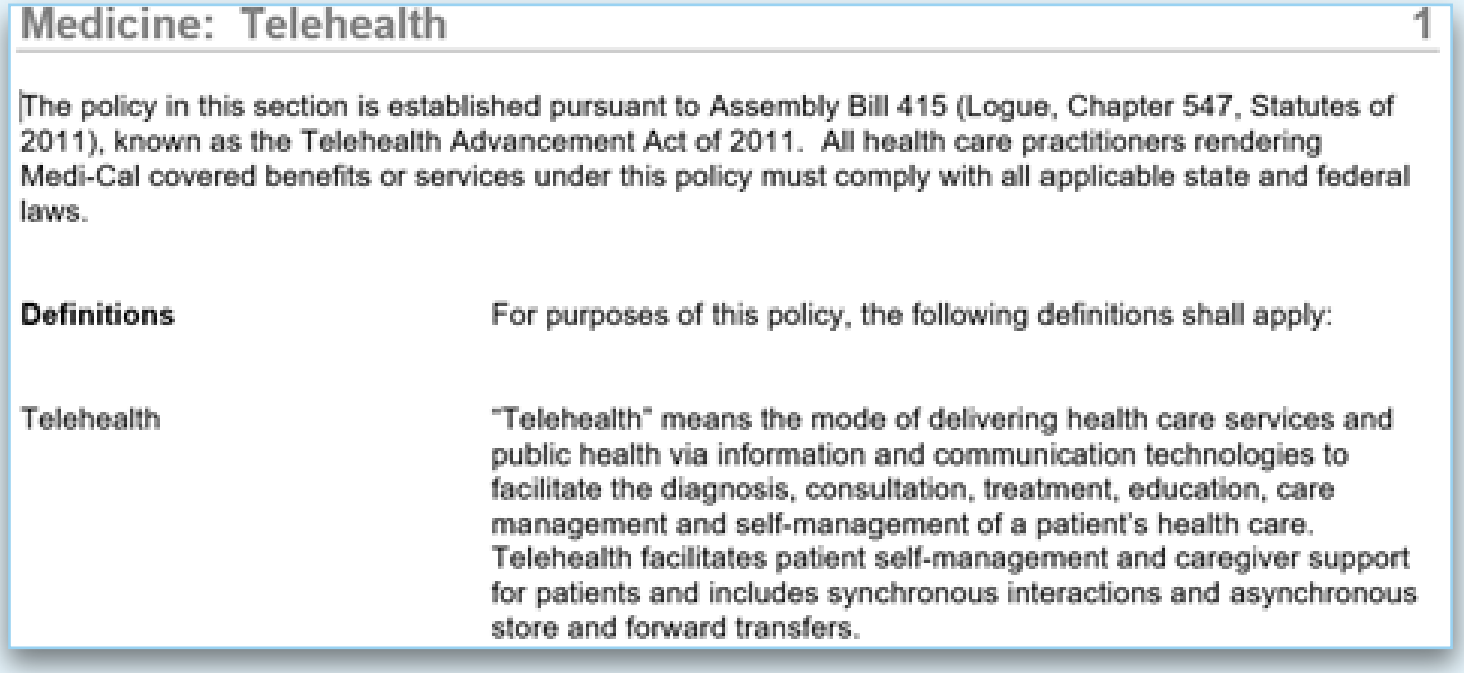
"Medi-Cal covered benefits and/or services, identified by Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes and subject to all existing Medi-Cal coverage and reimbursement policies, including any Treatment Authorization Request (TAR)/Service Authorization Request (SAR) requirements, may be provided via telehealth, as outlined in the "Medicine: Telehealth" Section of the Provider Manual, if all of the following are satisfied:

- The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT® or HCPCS code(s), as defined by the American Medical Association (AMA), associated with the Medi-Cal covered service or benefit, as well as any extended guidelines as described in this section of the Medi-Cal provider manual; and

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to his or her medical information."

http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/part2/mednetele_m01o03.doc



Medicine: Telehealth 1

The policy in this section is established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011. All health care practitioners rendering Medi-Cal covered benefits or services under this policy must comply with all applicable state and federal laws.

Definitions	For purposes of this policy, the following definitions shall apply:
Telehealth	"Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

For Medi-Cal Managed Care plan members, providers **should follow health plan procedures** for billing and/or submitting referrals for telehealth services.

COVID-19 update for Traditional Telehealth:

- Reporting POS 02 remains as appropriate for reporting
    - Synchronous, interactive audio and telecommunications systems: Modifier 95
    - Asynchronous store and forward telecommunications systems: Modifier GQ

Providers will utilize reported telehealth modifiers to identify that the covered Medi-Cal services were rendered via telehealth and were related to a COVID-19 diagnosis.

COVID-19 update for Synchronous Telehealth:

Medi-Cal benefits which include medical, mental health and substance use disorders, that are services rendered via a synchronous telehealth modality, must meet all of the criteria below:

- The treating practitioner at the distant site believes the Medi-Cal services being rendered are clinically appropriate based on evidence-based medicine and/or best practices to be delivered via telehealth, subject to oral or written consent by the Medi-Cal participant

- Examples of scenarios that would NOT be appropriate for delivery via telehealth:
    - Benefits or services that are performed in an operating room or while the patient is under anesthesia
    - Benefits or services that require direct visualization or instrumentation of bodily structures
    - Benefits or services that involve sampling of tissue or insertion/removal of medical devices

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

- Benefits or services that otherwise would require the in-person presence of the patient for any reason

- The benefits or services delivered via telehealth meet the procedural definition and components of the assigned CPT®/HCPCS as defined by the AMA

- The benefits or services delivered meets all the established laws regarding confidentiality of health care information and the patient's rights to his/her medical information

COVID-19 Medi-Cal Dental Benefits/services via Telehealth update:

- Medi-Cal participating dentists and Allied dental professionals (under the supervision of a dentist) can render limited services via synchronous/live transmission teledentistry, as long as the services being rendered are within their degree scope of practice

- When reporting D9995 for services via teledentistry, Medi-Cal policy is as follows:

  - CDT code D9995 is reimbursed at 0.24 cents per minute, up to a maximum of 90 minutes or $21.60 maximum reimbursement

  - D9995 may only be used once (1) per date of service per beneficiary, per provider

For Medi-Cal dental benefits, D9996 identified under dental services were rendered as tele-dentistry. CDT D9996 is NOT reimbursed, instead, the billing dental provider would be reimbursed based upon the applicable CDT procedure code and paid according to the SMA schedule.

The following table identifies the valid Medi-Cal Tele-dentistry codes that can be reported via asynchronous store and forward:

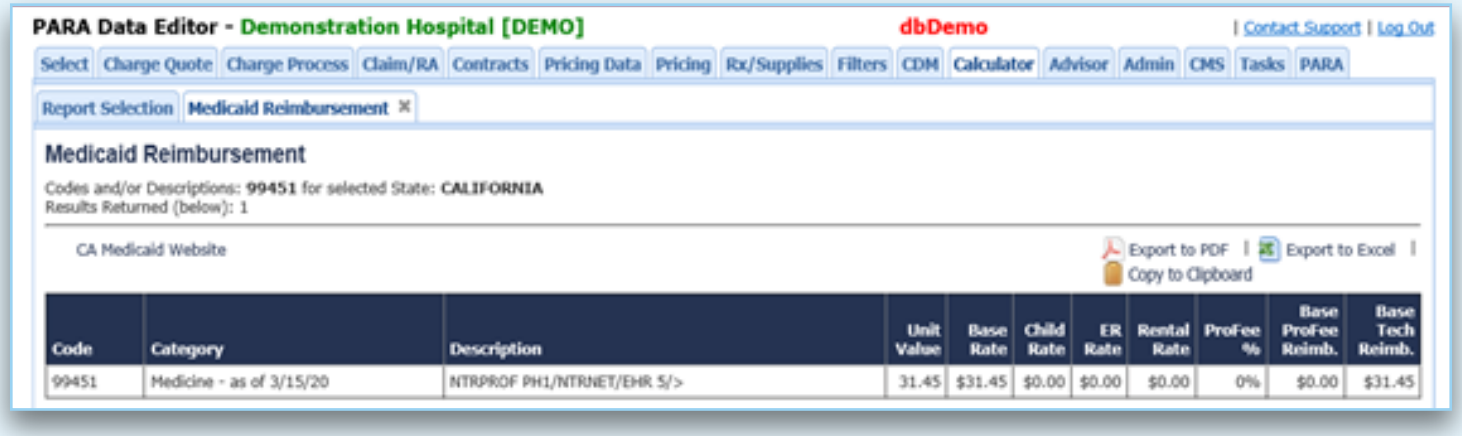
COVID-19 Medi-Cal Teledentistry	
Code	Description
D0120	Periodic oral evaluation – established patient
D0150	Comprehensive oral evaluation – new or established patient
D0210	Intraoral – complete series of radiographic images
D0220	Intraoral – periapical first radiographic image
D0230	Intraoral – periapical each additional radiographic image
D0240	Intraoral – occlusal radiographic image
D0270	Bitewing – single radiographic image
D0272	Bitewings – two radiographic images
D0274	Bitewings – four radiographic images
D0330	Panoramic radiographic image
D0350	Oral/Facial photographic images

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

COVID-19 Asynchronous Store and Forward, inclusive of E-Consults via Telehealth update:

Medi-Cal benefits are including but not limited to tele-ophthalmology, tele-dermatology, tele-dentistry and tele-radiology. These services may all be delivered via asynchronous store and forward, including E-Consults, when all of the criteria outlined below are met by providers:

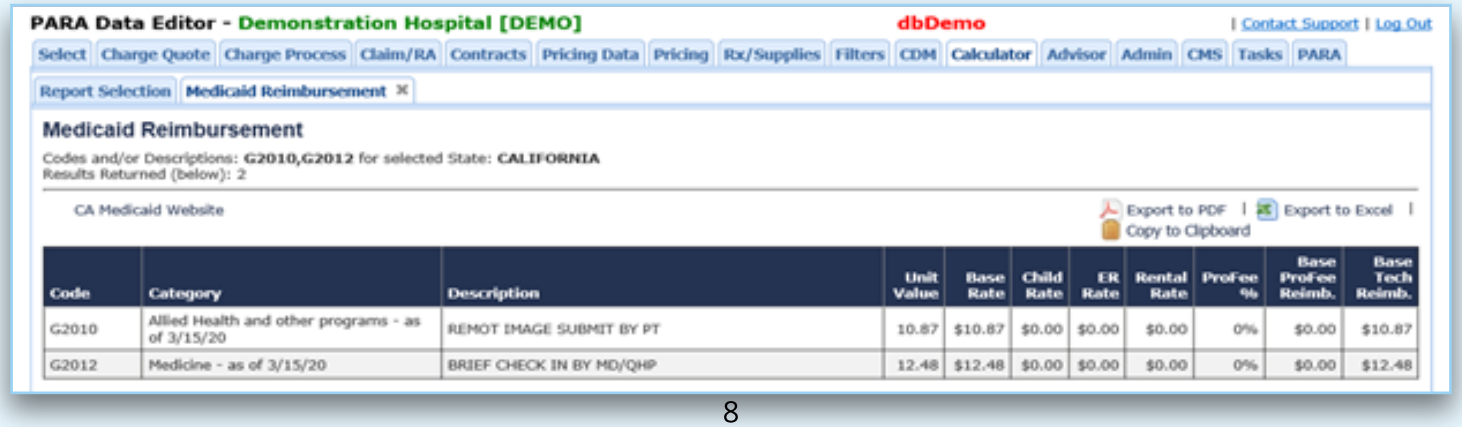
- Health care practitioner must ensure that the documentation, images, sent via store and forward be specific to the patient's condition and adequate for meeting the procedural definition and components of the assigned CPT®/HCPCS code that is submitted on the claim
- E-Consults must report the modifier GQ to designate the health care practitioner is the distant site consultant. This modifier is reported in conjunction with the assigned CPT®/HCPCS 99451
- CPT® code 99451 describes an inter-professional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified healthcare professional; 5 minutes or more in medical consultative time



COVID-19 Medi-Cal Other Virtual/Telephone Communication update:

For enrolled Medi-Cal providers, the policy below applies to services that are rendered in conjunction with a COVID-19 diagnosis.

Virtual Communication:This technology includes a brief communication with another practitioner or with a patient, and in the case of COVID-19, a patient who is not, cannot, or should not be physically present (face-to-face). In this case scenario, Medi-Cal participating providers may be reimbursed using the HCPCS codes indicated below, (G2010 and G2012):



COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

For Medi-Cal Managed Care plan members, providers are instructed to bill and/or submit a referral as indicated per health plan procedures.

Of note, the bulletin says virtual communication codes are billable by physicians and "nurses"; since Medi-Cal enrolls only advanced practice nurses, such as CRNAs, ARNPs, and nurse midwives, **PARA** presumes that the mention of nurses would be limited to those who have the advanced qualifications to become enrolled providers.

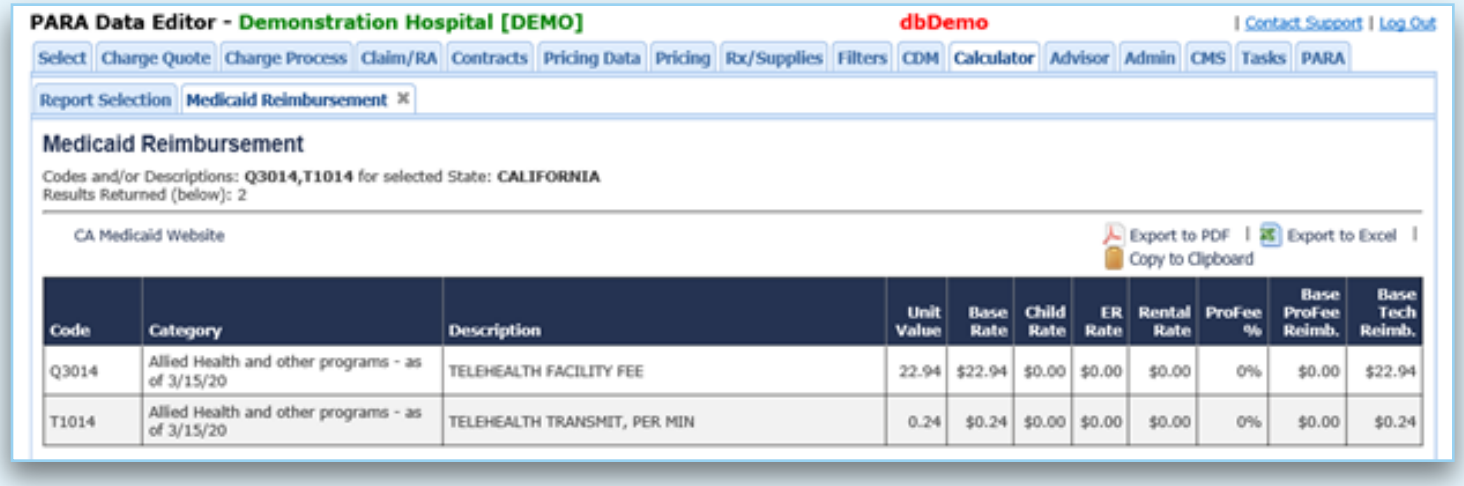
However, these services are **NOT billable** by:

- Federally Qualified Health Center (FQHC)
- Rural Health Clinics (RHC)
- Indian Health Services (IHS)
- Memorandum of Agreement (MOA) 638 Clinics

DHCS will issue future guidance to Medi-Cal providers, as needed, upon any approval with their Federal Partners via an 1135 Waiver Request for FQHCs, RHCs, IHS, and MOA.

COVID-19 Originating Site and Transmission Fee updates:

The originating site facility fee is reimbursed only to the originating site when billed with HCPCS Q3014. Transmission costs incurred from providing telehealth services via audio/video communication is reimbursed when billed with HCPCS T1014: telehealth transmission, per minute. Professional services are billed separately.



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

Report Selection | Medicaid Reimbursement

Medicaid Reimbursement

Codes and/or Descriptions: **Q3014,T1014** for selected State: **CALIFORNIA**
Results Returned (below): 2

CA Medicaid Website

Export to PDF | Export to Excel | Copy to Clipboard

Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
Q3014	Allied Health and other programs - as of 3/15/20	TELEHEALTH FACILITY FEE	22.94	$22.94	$0.00	$0.00	$0.00	0%	$0.00	$22.94
T1014	Allied Health and other programs - as of 3/15/20	TELEHEALTH TRANSMIT, PER MIN	0.24	$0.24	$0.00	$0.00	$0.00	0%	$0.00	$0.24

Medi-Cal has applied the following restrictions when reporting Q3014 and T1014 at the claim level:

- Q3014: Billable by originating site; once per day; same patient, same provider
- T1014: Originating site and distant site; maximum of 90 minutes per day (1 unit =1 minute), same patient, same provider
- Originating site fee and transmission costs are NOT available for telephonic services
- Providers, if billing store and forward, including e-consults at the originating site may bill originating site fee with HCPCS code Q3014, but may not bill for the transmission fee.Further, providers originating site and transmission fee restrictions are NOT applicable to FQHCs, RHCs, or Tribal 638 clinics.

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

New: Billing Instructions for Presumptive Eligibility (PE) for COVID-19 Program:

On April 08, 2020, The California Department of Health Care Services (DHCS) implemented Presumptive Eligibility (PE) benefits for the coronavirus disease (COVID-19).

Medi-Cal benefits are available for individuals with no health insurance or who currently have private insurance that does not have benefits to cover diagnostic testing, testing-related service and treatment services, which includes all medically necessary care as a result of COVID-19.

Eligibility for COVID-19 will use the established Aid Code of V2 to determine the limited benefits for these individuals. Aid Code V2 is a limited-scope code that will allow access to COVID-19 diagnostic testing, testing-related service and treatment services, which include all medically necessary care for COVID-19 including laboratory services and the associated office, clinic or emergency room visits, without regard to immigration status, income or resources.

Providers should note: Aid Code V2 will be assigned a date specific eligibility. A Qualified Provider (QP) will enroll the individual on the date of application and their PE eligibility will end on the last calendar day of the month in which the 60th day falls from the date of their PE application.

Providers must include the ICD-10 diagnosis code U07.1 on all claims for COVID-19 claim reimbursement. Claims submitted without this diagnosis will be denied.

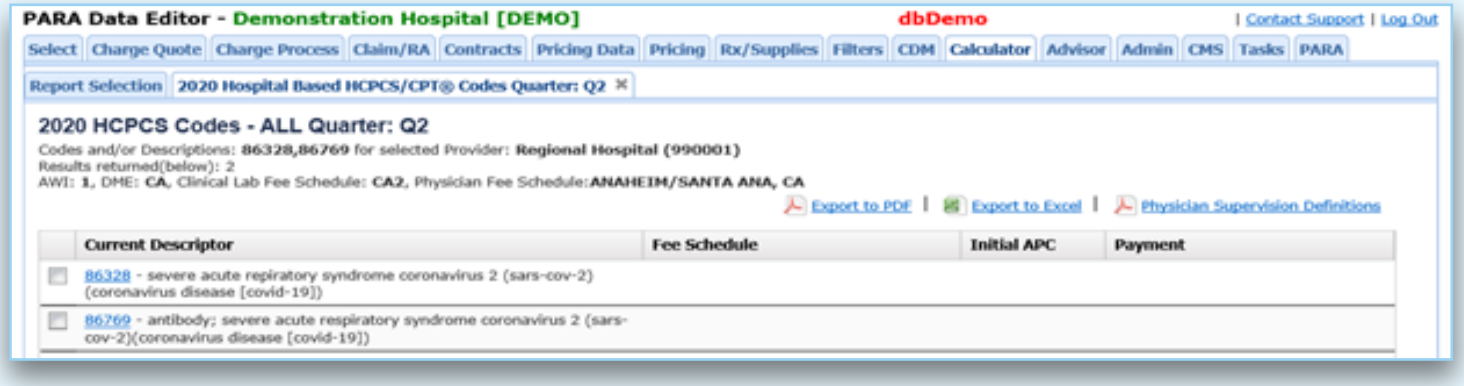
Update On Laboratory Diagnostic Testing:

Effective for dates of service on or after April 10, 2020, the AMA has released the following specific codes which will be utilized to report and track COVID-19 antibody testing.

In doing so, the AMA has revised code 86318(immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method) and established 86328 (immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and 86769 (antibody, severe acute respiratory syndrome coronavirus, to provide increased specificity to report serologic laboratory testing.

Frequency requirements for codes 86328 and 86769 apply as follows:

- 86328 and 86769 have an assigned frequency limit of two per day
- 68328 and 86769 may NOT be billed with each other on the same date of service



COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

DHCS has implemented three new HCPCS codes (U0001, U0002, 87635) which will be retro-active for dates of service on or after February 04, 2020.

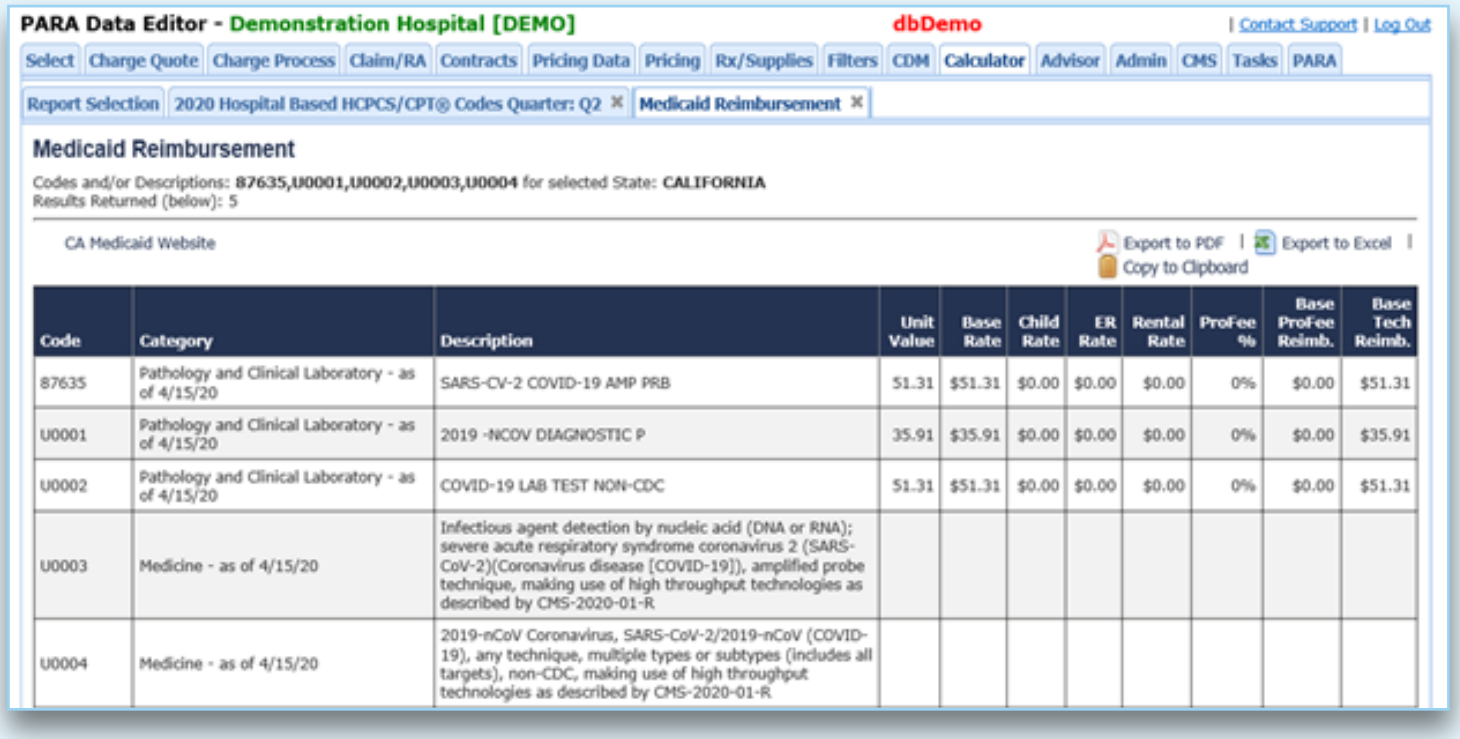
Reimbursement established:

Effective for dates of service on or after March 13, 2020, the Centers for Medicare and Medicaid Services (CMS) established Current Procedural Terminology (CPT®) code 87635 (SARS-COV-2 COVID-19 AMP PRB) for COVID-19 diagnostic testing services. When billing, providers may be reimbursed up to $51.31 for these services.

May update:

New HCPCS for COVID-19 Diagnosis:Effective for dates service on or after March 18, 2020, Medi-Cal will reimburse for HCPCS U0003 and U0004. Medi-Cal has the following restrictions linked to the utilization of these codes at the claim level:

- U0003 and U0004 have a frequency limit of two (2) of each test per day, per patient, on the same DOS
- U0003 and U0004 are eligible as a Presumptive Eligible Benefit
- U0003 and U0004 are billable with modifiers 33, 59, 90 and 99
- U0003 and U0004 are not reimbursed when billed with each other, 87635, U0001 and U0002



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

Report Selection | 2020 Hospital Based HCPCS/CPT® Codes Quarter: Q2 | Medicaid Reimbursement

Medicaid Reimbursement

Codes and/or Descriptions: **87635,U0001,U0002,U0003,U0004** for selected State: **CALIFORNIA**
Results Returned (below): 5

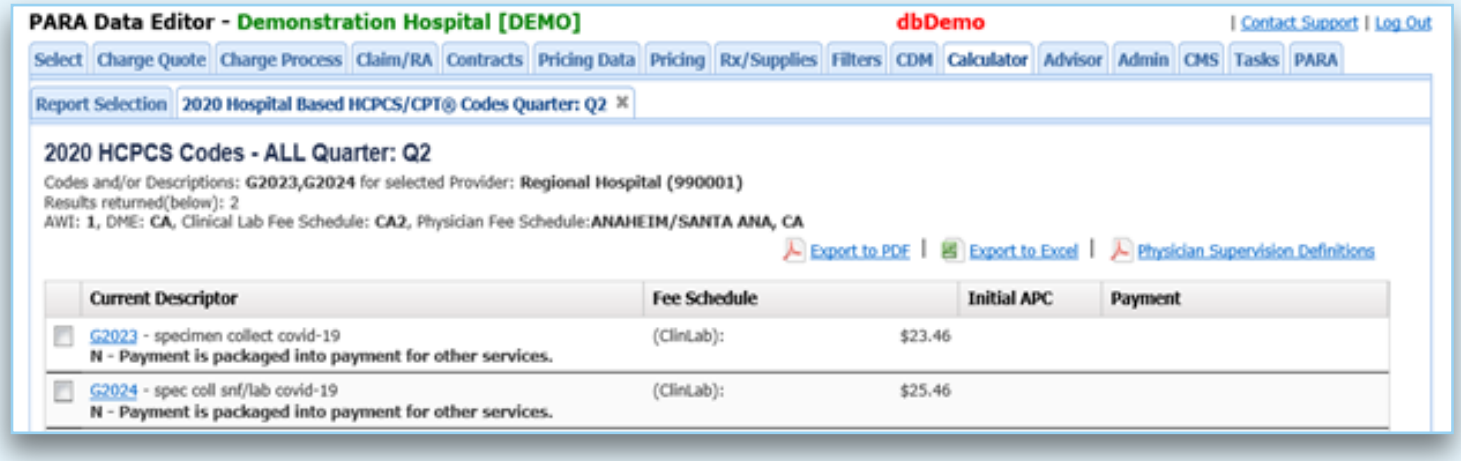
CA Medicaid Website | Export to PDF | Export to Excel | Copy to Clipboard

Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
87635	Pathology and Clinical Laboratory - as of 4/15/20	SARS-CV-2 COVID-19 AMP PRB	51.31	$51.31	$0.00	$0.00	$0.00	0%	$0.00	$51.31
U0001	Pathology and Clinical Laboratory - as of 4/15/20	2019 -NCOV DIAGNOSTIC P	35.91	$35.91	$0.00	$0.00	$0.00	0%	$0.00	$35.91
U0002	Pathology and Clinical Laboratory - as of 4/15/20	COVID-19 LAB TEST NON-CDC	51.31	$51.31	$0.00	$0.00	$0.00	0%	$0.00	$51.31
U0003	Medicine - as of 4/15/20	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)(Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R								
U0004	Medicine - as of 4/15/20	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R								

May 2020 Update:

Specimen Collection for COVID-19:Effective for dates of service on or after March 01, 2020, HCPCS G2023 and G2024 are now Medi-Cal benefits. These codes are billable by clinical diagnostic laboratories

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE



Diagnosis Coding:

Currently, the Medi-Cal billing system is programmed to edit for any ICD-10 diagnosis codes identified by the Centers for Disease Control and Prevention (CDC) and the World Health Organization. DHCS is encouraging Medi-Cal participating providers to review the links below for assistance in diagnosis coding for COVID-19.

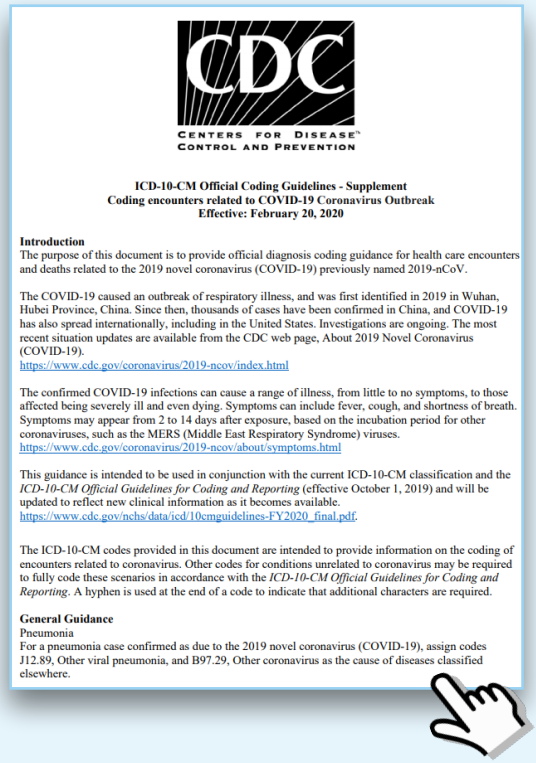
COVID-19 Diagnosis update:

Medi-Cal is allowing U07.1 for claims related to COVID-19 services effective on or after April 01, 2020.

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf

New: CPT® Codes for COVID-19 Anti-body Testing: Effective for dates of service on or after April 10, 2020, the AMA has released CPT codes 86318, 86328 and 86769 to allow for increased specificity to report serologic laboratory testing.

Codes 86328 and 86769 both have restrictive frequency limits of two per day and may NOT be billed with each other on the SAME date of service.



CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

ICD-10-CM Official Coding Guidelines - Supplement
Coding encounters related to COVID-19 Coronavirus Outbreak
Effective: February 20, 2020

Introduction
The purpose of this document is to provide official diagnosis coding guidance for health care encounters and deaths related to the 2019 novel coronavirus (COVID-19) previously named 2019-nCoV.

The COVID-19 caused an outbreak of respiratory illness, and was first identified in 2019 in Wuhan, Hubei Province, China. Since then, thousands of cases have been confirmed in China, and COVID-19 has also spread internationally, including in the United States. Investigations are ongoing. The most recent situation updates are available from the CDC web page, About 2019 Novel Coronavirus (COVID-19).
https://www.cdc.gov/coronavirus/2019-ncov/index.html

The confirmed COVID-19 infections can cause a range of illness, from little to no symptoms, to those affected being severely ill and even dying. Symptoms can include fever, cough, and shortness of breath. Symptoms may appear from 2 to 14 days after exposure, based on the incubation period for other coronaviruses, such as the MERS (Middle East Respiratory Syndrome) viruses.
https://www.cdc.gov/coronavirus/2019-ncov/about/symptoms.html

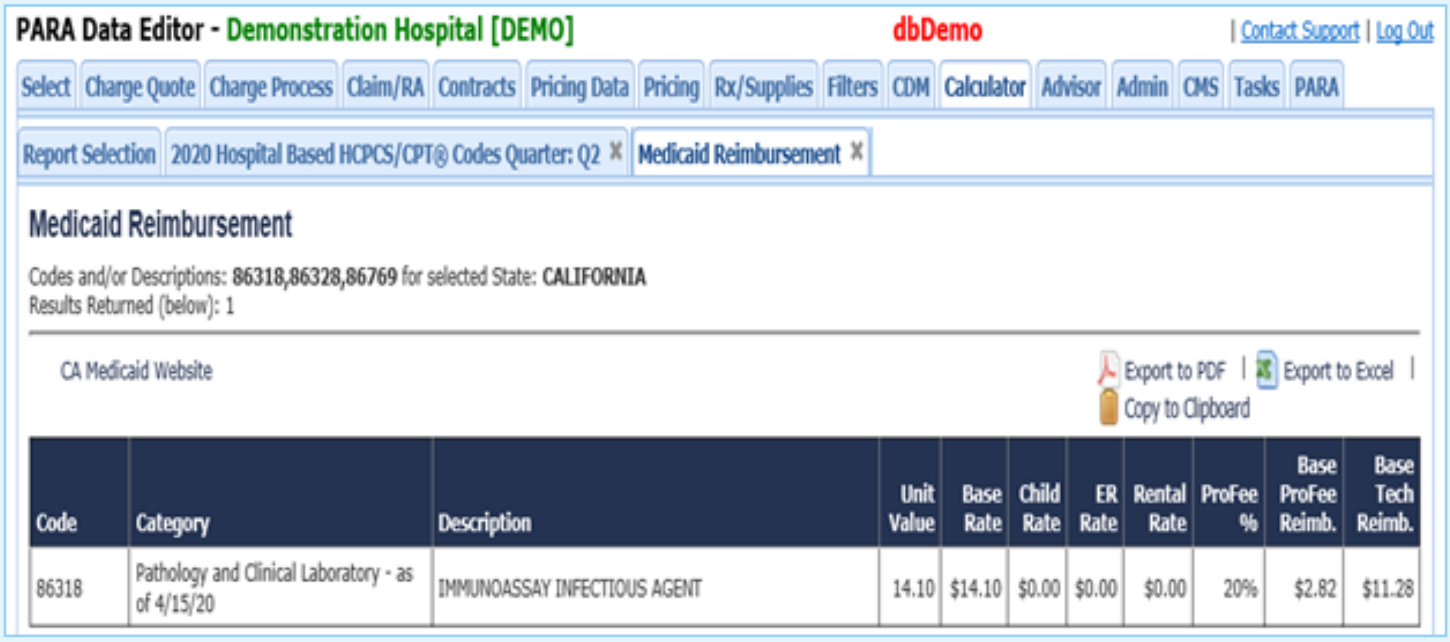
This guidance is intended to be used in conjunction with the current ICD-10-CM classification and the *ICD-10-CM Official Guidelines for Coding and Reporting* (effective October 1, 2019) and will be updated to reflect new clinical information as it becomes available.
https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf.

The ICD-10-CM codes provided in this document are intended to provide information on the coding of encounters related to coronavirus. Other codes for conditions unrelated to coronavirus may be required to fully code these scenarios in accordance with the *ICD-10-CM Official Guidelines for Coding and Reporting*. A hyphen is used at the end of a code to indicate that additional characters are required.

General Guidance
Pneumonia
For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes J12.89, Other viral pneumonia, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

The update manual pages for this change will be released in a future Medi-Cal Update



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Report Selection | 2020 Hospital Based HCPCS/CPT® Codes Quarter: Q2 | Medicaid Reimbursement

Medicaid Reimbursement

Codes and/or Descriptions: **86318,86328,86769** for selected State: **CALIFORNIA**
Results Returned (below): 1

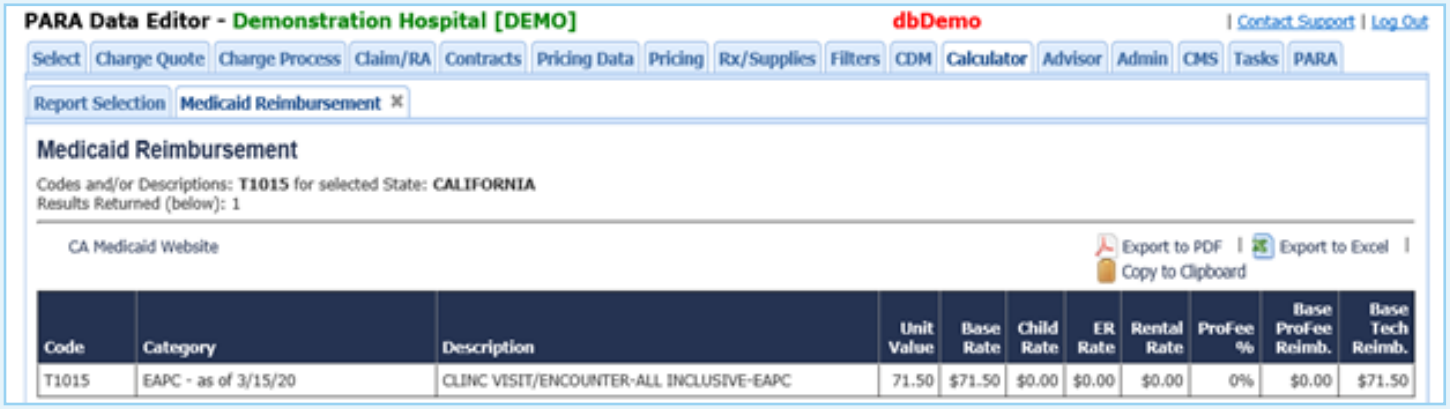
CA Medicaid Website — Export to PDF | Export to Excel | Copy to Clipboard

Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
86318	Pathology and Clinical Laboratory - as of 4/15/20	IMMUNOASSAY INFECTIOUS AGENT	14.10	$14.10	$0.00	$0.00	$0.00	20%	$2.82	$11.28

COVID-19 Traditional Telehealth (Synchronous or Asynchronous) Policy updates for FQHCs, RHCs, and Tribal 638 Clinics:

For FQHCs, RHCs and Tribal 638 Clinics, participating providers may provide Medi-Cal covered benefits/services via synchronous telehealth to ESTABLISHED PATIENTS. Medi-Cal defines an established patient as those patients that have not been seen at the FQHC, RHC or Tribal 638 Clinic within the last three years.

Medi-Cal covered benefits or services that have been rendered via synchronous telehealth, FQHCs, RHC and Tribal 638 Clinics should report the telehealth services using T1015. Services reported under T1015 are reimbursed at the All-inclusive Rate (AIR).



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

Report Selection | Medicaid Reimbursement

Medicaid Reimbursement

Codes and/or Descriptions: **T1015** for selected State: **CALIFORNIA**
Results Returned (below): 1

CA Medicaid Website — Export to PDF | Export to Excel | Copy to Clipboard

Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
T1015	EAPC - as of 3/15/20	CLINC VISIT/ENCOUNTER-ALL INCLUSIVE-EAPC	71.50	$71.50	$0.00	$0.00	$0.00	0%	$0.00	$71.50

For COVID-19, FQHC, RHC and Tribal 638 Clinics, Medi-Cal covered benefits outside of the four walls, may be provided via synchronous telehealth for certain populations pursuant to applicable federal law, including migrant/seasonal workers, homeless individuals, and homebound individuals.FQHCs, RHCs and Tribal 638 Clinics, cannot bill for e-Consults or telephone visits.

CMS WAIVER DETAILS HOSPITAL THERAPIST REMOTE SERVICES

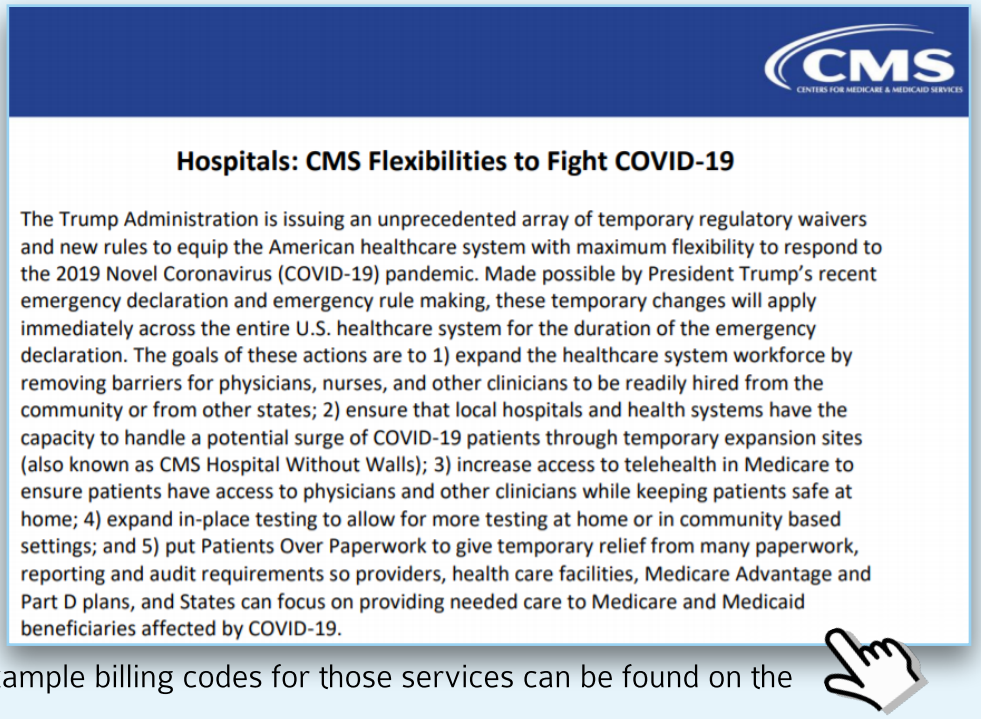
A CMS publication at the following link discusses this topic on pages 3 and 4:

https://www.cms.gov/files/document/covid-hospitals.pdf

- **Hospital-Only Remote Outpatient Therapy and Education Services:** Consistent with the CMS Hospitals without Walls Initiative, we have announced that hospitals may provide behavioral health and education services furnished by hospital-employed counselors or other professionals that cannot bill Medicare directly for their professional services.

  This includes partial hospitalization services. These services may be furnished to a beneficiary in their home when the beneficiary is registered as an outpatient of the hospital and the hospital considers the beneficiary's home to be a provider-based department of the hospital.

  - During the PHE, a subset of therapy and educational services are eligible to be provided remotely by the hospital clinical staff so long as they are furnished to a patient in the hospital, which may include the patient's home if that home is made provider-based to the hospital during the PHE. A list of example billing codes for those services can be found on the cms.gov website



  - Counselors and other employed hospital staff may furnish these services to the beneficiary, either through telecommunications technology or in person, in a temporary expansion location, which may include the beneficiary's home so long as it has been made provider-based to the hospital

  - For Partial Hospitalization Program services, hospitals can furnish and bill for certain partial hospitalization service—that is, individual psychotherapy, patient education, and group psychotherapy--that are delivered in temporary expansion locations, including patients' homes, so long as such locations have been made provider-based to the hospital, to ensure access to necessary services and maintain continuity of care and for purposes of infection control. When the patient is registered as an outpatient, PHP services furnished by hospital staff in that location are considered to be furnished in the hospital

  - The hospital may bill for these services as hospital outpatient services, as long as they are medically necessary and meet all requirements described by the HCPCS code, and as long as the service in furnished in a hospital outpatient department of the hospital

CMS WAIVER DETAILS HOSPITAL THERAPIST REMOTE SERVICES

Within the document linked on the previous page, CMS provided a chart of the various payment methodologies applicable to services performed at extension sites of a provider-based department of the hospital (e.g., patient homes) during the COVID-19 emergency is provided on this page.

Provider-Based Department (PBD) Type	Non-PHE Payment Policy Before Relocation	Non-PHE Payment Policy if PBD Relocates Off-Campus (Absent Extraordinary Circumstance Approval)	Payment Policy During PHE Following Off-Campus Relocation
On-Campus PBD	Full OPPS	PFS-equivalent (treated as new location)	Full OPPS*
Excepted* Off-Campus PBD	Full OPPS	PFS-equivalent (treated as new location)	Full OPPS*
Non-Excepted Off-Campus PBD	PFS-equivalent	PFS-equivalent	PFS-equivalent
New (since pandemic) Off-Campus PBD	PFS-equivalent	PFS-equivalent	PFS-equivalent

*PBD department relocations would need to receive extraordinary circumstances relocation approval and the relocation must not be inconsistent with state emergency preparedness or pandemic plan. Once the COVID-19 PHE ends, these relocated PBD would be expected to shut down or return to their original location; otherwise, they would be paid the PFS-equivalent rate unless, at the discretion of the CMS Regional Office, they are granted a permanent extraordinary circumstances relocation exception under our normal policy. We note that, during the COVID-19 PHE, hospitals would have flexibility to do partial relocations, and relocate their PBD to multiple new off-campus locations, including the patient's home.

CMS ANNOUNCES ADDED COVID-19 REIMBURSEMENT

On April 30, 2020, CMS announced several updates to its policies on payment for services during the COVID-19 National Health Emergency.Updates of particular interest to hospitals include:

- **A new HCPCS (C9803 - Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), any specimen source)) will reimburse outpatient hospitals for collecting COVID-19 test swabs** at the Medicare national unadjusted APC rate of $22.98. Under OPPS, Medicare will make separate payment to an OPPS hospital when HCPCS code C9803 is billed without another primary covered hospital outpatient service, and also will make separate payment for C9803 when it is billed with a clinical diagnostic laboratory test with a status indicator of "A" on Addendum B, such as the COVID-19 test codes (i.e. U0001, U0002, 87635).

  The memorandum permitting this reimbursement is dated April 30, 2020, and is "effective immediately". **PARA** has requested clarification from CMS as to whether this code will be allowed retroactively

- **Hospitals which provide the outpatient environment for practitioners billing professional fees for telehealth services may report the telehealth originating site fee, Q3014,** for reimbursement, apparently retroactive to March 1, 2020.CMS states "Therefore, during the COVID-19 PHE, when telehealth services are furnished by a physician or practitioner who ordinarily practices in the HOPD to a patient who is located at home ..., we believe it would be appropriate to permit the hospital to bill and be paid the originating site facility fee amount for those telehealth services, just as they would have ordinarily done outside of the COVID-19 PHE in this circumstance. ... As always, documentation in the medical record of the reason for the visit and the necessity of the visit is required."

- **Hospital clinical staff may bill for telehealth therapy services on an outpatient hospital claim form.Retroactive to March 1, 2020, physical, occupational, speech language pathology therapists, and staff providing Partial Hospitalization services** may report services from the Telehealth list when providing care to a patient in the home over communications technology.

  Previously, only therapists billing on a professional fee claim form were allowed to provide limited remote services (e-Visits, Virtual Check-Ins, and limited telephone services) to patients in the home. With the expansion announced on 4/30/2020, the listed telehealth services appropriate for therapists may be billed on either a professional fee claim form or by a hospital outpatient department on a facility fee claim form.

- **Some (but not all) telehealth services may be performed using a telephone only**--previously CMS required real-time audio and video technology for the delivery of telehealth.The updated telehealth list includes a new column to identify such services. The list is available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

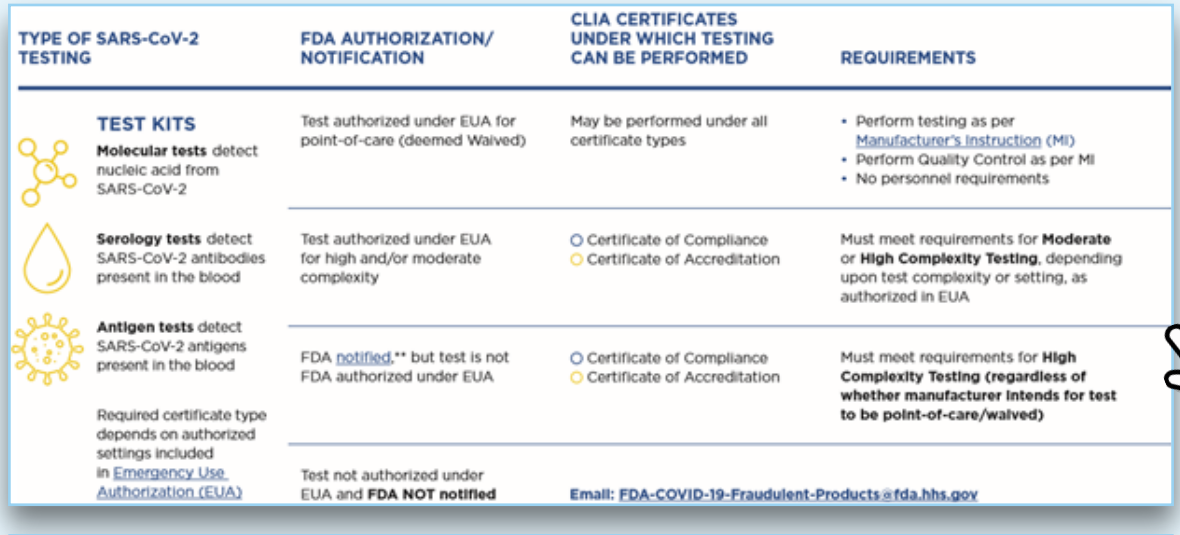
CMS ANNOUNCES ADDED COVID-19 REIMBURSEMENT

- **Free-standing physician practices may report CPT® 99211 for COVID-19 swab collection** for both new and established patients, in cases where no other E/M service is rendered (e.g., drive-through testing sites). CMS has indicated that no patient liability will be adjudicated "if the service results in an order to test for COVID"–which implies that the CS modifier would be required for such coverage

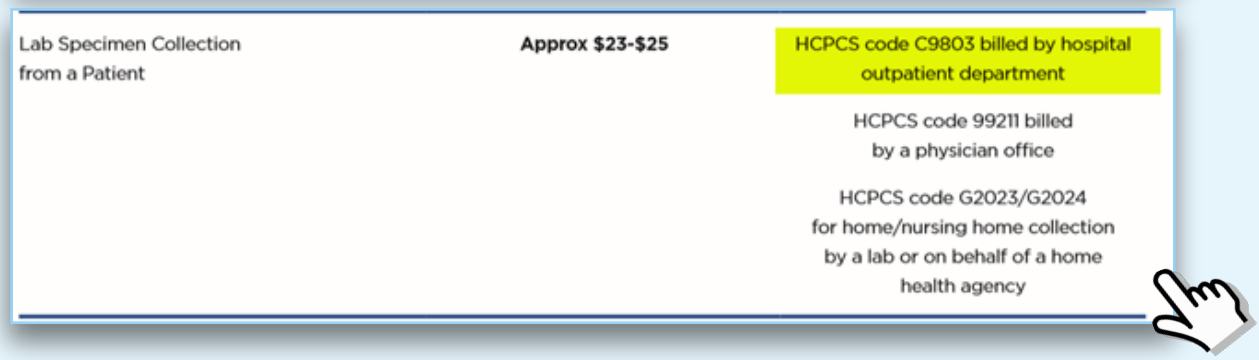
The announcements were fragmented among several documents.The following general announcement, which relates changes to rules and regulations to a wide variety of healthcare providers, is found at:

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Outpatient hospital reimbursement for swab collection is detailed at the following website: https://www.cms.gov/files/document/admin-info-20-06-clia.pdf



TYPE OF SARS-CoV-2 TESTING	FDA AUTHORIZATION/ NOTIFICATION	CLIA CERTIFICATES UNDER WHICH TESTING CAN BE PERFORMED	REQUIREMENTS
TEST KITS **Molecular tests** detect nucleic acid from SARS-CoV-2	Test authorized under EUA for point-of-care (deemed Waived)	May be performed under all certificate types	• Perform testing as per Manufacturer's Instruction (MI) • Perform Quality Control as per MI • No personnel requirements
Serology tests detect SARS-CoV-2 antibodies present in the blood	Test authorized under EUA for high and/or moderate complexity	○ Certificate of Compliance ○ Certificate of Accreditation	Must meet requirements for **Moderate** or **High Complexity Testing**, depending upon test complexity or setting, as authorized in EUA
Antigen tests detect SARS-CoV-2 antigens present in the blood	FDA notified,** but test is not FDA authorized under EUA	○ Certificate of Compliance ○ Certificate of Accreditation	Must meet requirements for **High Complexity Testing (regardless of whether manufacturer intends for test to be point-of-care/waived)**
Required certificate type depends on authorized settings included in Emergency Use Authorization (EUA)	Test not authorized under EUA and **FDA NOT notified**	**Email:** FDA-COVID-19-Fraudulent-Products@fda.hhs.gov	



Lab Specimen Collection from a Patient	**Approx $23-$25**	HCPCS code C9803 billed by hospital outpatient department HCPCS code 99211 billed by a physician office HCPCS code G2023/G2024 for home/nursing home collection by a lab or on behalf of a home health agency

CMS ANNOUNCES ADDED COVID-19 REIMBURSEMENT

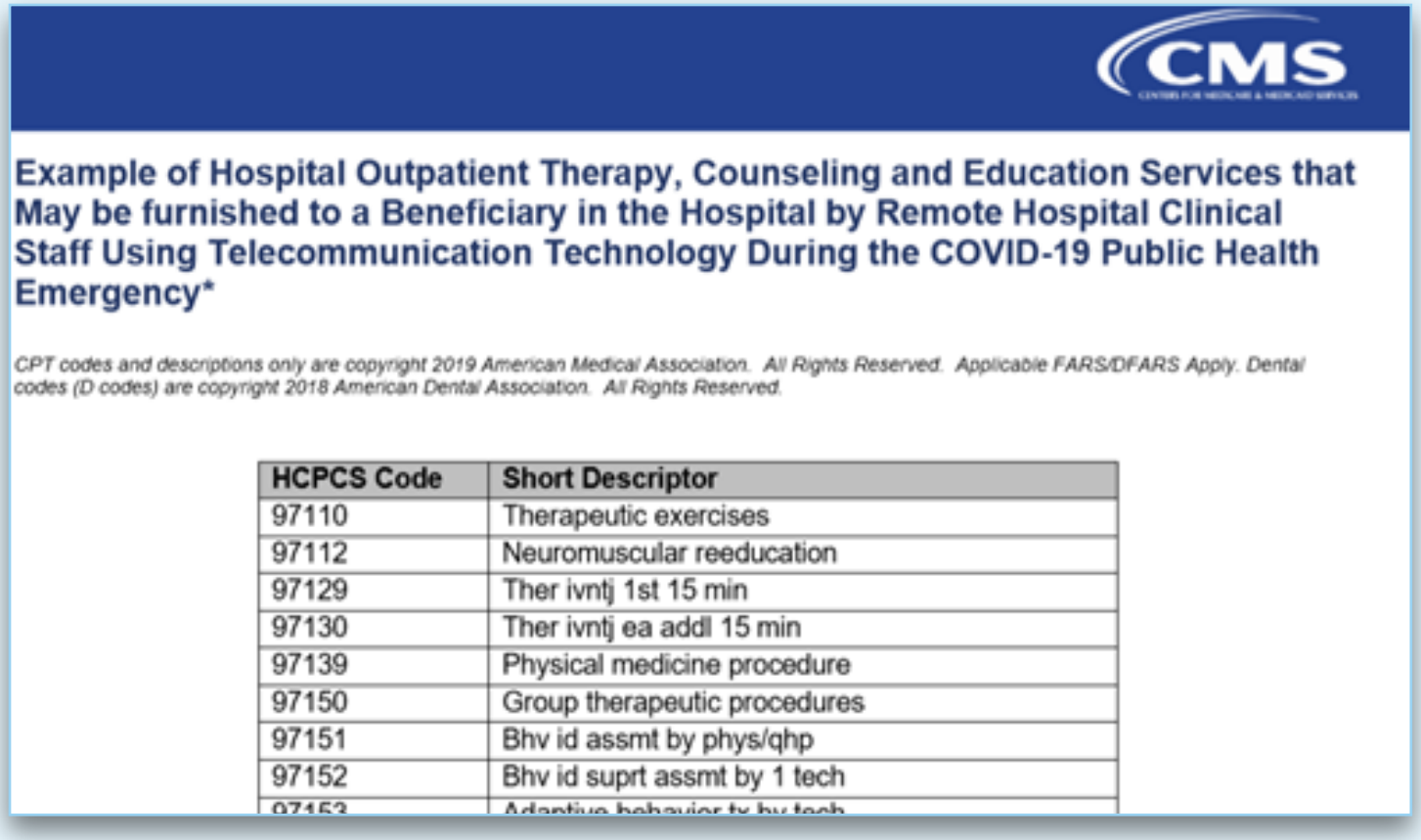
Reimbursement of the originating site fee for telehealth provided to patients in their homes is found on page 58 of the Interim Final Rule with Comment Period (IFC). A link and an excerpt are provided:

https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

> "As such, for the duration of the COVID-19 PHE, we are making the public aware that under the flexibilities already in effect, when a patient is receiving a professional service via telehealth in a temporary expansion location that is a PBD of the hospital, and the patient is a registered outpatient of the hospital, the hospital in which the patient is registered may bill the originating site facility fee for the service.As always, documentation in the medical record of the reason for the visit and the necessity of the visit is required."

Hospital-based Physical, Occupational, and Speech Language Pathology therapists, and Partial Hospitalization Program telehealth capabilities are addressed beginning on page 46 of the interim final rule (link above), and in attachments from the CMS Current Emergencies webpage:

https://www.cms.gov/files/zip/covid-ifc-2-list-hospital-outpatient-services.zip



Example of Hospital Outpatient Therapy, Counseling and Education Services that May be furnished to a Beneficiary in the Hospital by Remote Hospital Clinical Staff Using Telecommunication Technology During the COVID-19 Public Health Emergency*

CPT codes and descriptions only are copyright 2019 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental codes (D codes) are copyright 2018 American Dental Association. All Rights Reserved.

HCPCS Code	Short Descriptor
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97129	Ther ivntj 1st 15 min
97130	Ther ivntj ea addl 15 min
97139	Physical medicine procedure
97150	Group therapeutic procedures
97151	Bhv id assmt by phys/qhp
97152	Bhv id suprt assmt by 1 tech
97153	Adaptive behavior tx by tech

"*Notes: Effective as of March 1, 2020 and for the duration of the COVID-19 Public Health Emergency (PHE), hospital outpatient services can be furnished when the patient, who is a registered outpatient of the hospital, is in a temporary expansion location, including his or her home, when such a location is considered to be a provider-based department of the hospital as permitted under the waivers in effect during the COVID-19 PHE."

CMS ADDS FACILITY PAY FOR TELEHEALTH HOPD PRO FEES

On April 30, 2020, CMS announced further expansions to meet the COVID-19 National Health Emergency that provides additional facility-fee reimbursement for outpatient telehealth professional services provided by hospital-based practitioners working through a hospital outpatient department (HOPD.)

Previously, CMS had indicated that during the National Health Emergency, professionals reporting telehealth services should indicate the Place of Service code that would have been reported if the provider had seen the patient in person.

The POS code drives higher Medicare Physician Fee Schedule reimbursement for physicians practicing at independent clinics, and less reimbursement for those who report a POS code for an outpatient department of the hospital.Regardless, the professional fee should report modifier 95 to indicate the service was provided over communications technology.

For example, a provider reporting a telehealth service during the COVID-19 emergency with CPT® 99213 (modifier 95) and POS code 11 (Office), would be reimbursed $83.73 under the Medicare Physician Fee Schedule (national unadjusted rate).

However, a physician reporting the same service with POS 22—Outpatient Hospital—would be paid less: $55.72.The lower facility-based reimbursement reflects the ordinary expectation that a hospital facility fee would be generated for a patient visit to the hospital. But under the first set of COVID-19 waivers, facilities were not permitted to be reimbursed for telehealth services delivered by provider-based practitioners.

	Current Descriptor	Fee Schedule	
☐	99213 - office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. usua **B - Not paid under OPPS.**	GB (Physician Facility): GB (Physician Non-Facility):	$55.72 $83.73

This situation left facilities providing the scheduling, billing, and medical records for provider-based practitioners without any reimbursement for the facility's contribution toward the delivery of telehealth.

To rectify this imbalance, effective March 1, 2020, CMS will reimburse facilities reporting the Telehealth Originating Site Fee (HCPCS Q3014, paid at $26.65 nationally), when a professional fee for telehealth is reported by a hospital-based provider.

Here is a link and excerpts from the CMS Interim Final Rule published on April 30, 2020, pages 55 through 58: cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

CMS ADDS FACILITY PAY FOR TELEHEALTH HOPD PRO FEES

Notice: This HHS-approved document will be submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the **Federal Register**. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. The document published in the **Federal Register** is the official HHS-approved document.

[Billing Code: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 410, 412, 413, 414, 415, 424, 425, 440, 483, 484 and 600

Office of the Secretary

45 CFR Part 156

[CMS-5531-IFC]

RIN 0938-AU32

Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period (IFC) gives individuals and entities that provide services to Medicare, Medicaid, Basic Health Program, and Exchange beneficiaries needed flexibilities to respond effectively to the serious public health threats posed by the spread of the coronavirus disease 2019 (COVID-19). Recognizing the critical importance of expanding COVID-19 testing we are amending several Medicare policies on an interim basis to cover FDA-authorized COVID-19 serology tests, to allow any healthcare professional authorized to do so

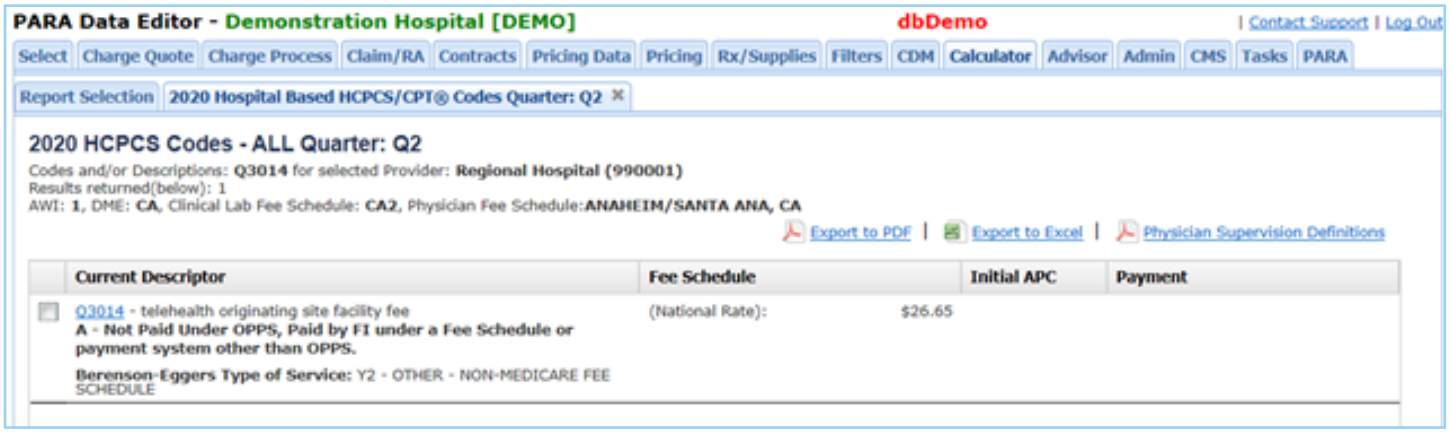
"We acknowledge that when a physician or practitioner who ordinarily practices in the HOPD furnishes a telehealth service to a patient who is located at home, the hospital would often still provide some administrative and clinical support for that service. When a registered outpatient of the hospital is receiving a telehealth service, the hospital may bill the originating site facility fee to support such telehealth services furnished by a physician or practitioner who ordinarily practices there.

This includes patients who are at home, when the home is made provider-based to the hospital (which means that all applicable conditions of participation, to the extent not waived, are met), under the current waivers in effect for the COVID-19 PHE.

...

"As such, for the duration of the COVID-19 PHE, we are making the public aware that under the flexibilities already in effect, when a patient is receiving a professional service via telehealth in a temporary expansion location that is a PBD of the hospital, and the patient is a registered outpatient of the hospital, the hospital in which the patient is registered may bill the originating site facility fee for the service.

As always, documentation in the medical record of the reason for the visit and the necessity of the visit is required."Consequently, hospitals should claim reimbursement for Q3014 (telehealth originating site facility fee) for each hospital-based practitioner's telemedicine encounter reporting Place of Service code 22 (outpatient hospital) provided on or after March 1, 2020



HOW PRICE TRANSPARENCY WORKS: THE PARA PRODUCT

Price transparency continues to be an important topic in healthcare, especially as the Centers for Medicare & Medicaid Services (CMS) have continued to issue regulations. In order to meet the mandatory requirements imposed by CMS for the Price Transparency deadline of 01/01/2021 and the previous one of 01/01/02019, hospitals must comply with the following:

- Publish in a machine-readable format a complete listing of all services and charges available at the hospital
- Publish in a machine-readable format payer specific reimbursement information and the deidentified high, low, average, and median rates for all services and charges available at the hospital
- Publish in a machine-readable format the 70 services CMS has defined plus 230+ services at the discretion of the hospital with payer specific reimbursement information and de-identified high, low, average, and median rates

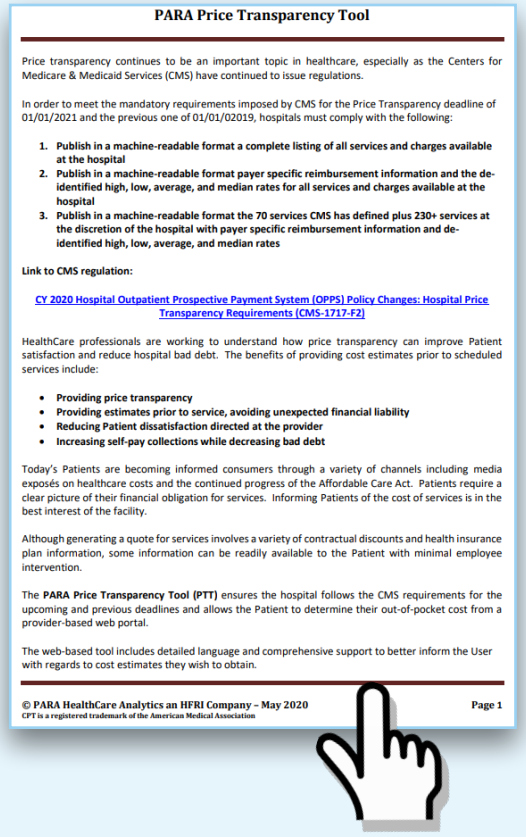
Link to CMS regulation:

CY 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes: Hospital Price Transparency Requirements (CMS-1717-F2)

Healthcare professionals are working to understand how price transparency can improve Patient satisfaction and reduce hospital bad debt. The benefits of providing cost estimates prior to scheduled services include:

- Providing price transparency
- Providing estimates prior to service, avoiding unexpected financial liability
- Reducing Patient dissatisfaction directed at the provider
- Increasing self-pay collections while decreasing bad debt

The **PARA Price Transparency Tool** ensures the hospital follows the CMS requirements for the upcoming and previous deadlines and allows the patient to determine their out-of-pocket cost from a provider-based web portal.



PARA Price Transparency Tool

Price transparency continues to be an important topic in healthcare, especially as the Centers for Medicare & Medicaid Services (CMS) have continued to issue regulations.

In order to meet the mandatory requirements imposed by CMS for the Price Transparency deadline of 01/01/2021 and the previous one of 01/01/02019, hospitals must comply with the following:

1. **Publish in a machine-readable format a complete listing of all services and charges available at the hospital**
2. **Publish in a machine-readable format payer specific reimbursement information and the de-identified high, low, average, and median rates for all services and charges available at the hospital**
3. **Publish in a machine-readable format the 70 services CMS has defined plus 230+ services at the discretion of the hospital with payer specific reimbursement information and de-identified high, low, average, and median rates**

Link to CMS regulation:

CY 2020 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes: Hospital Price Transparency Requirements (CMS-1717-F2)

HealthCare professionals are working to understand how price transparency can improve Patient satisfaction and reduce hospital bad debt. The benefits of providing cost estimates prior to scheduled services include:

- **Providing price transparency**
- **Providing estimates prior to service, avoiding unexpected financial liability**
- **Reducing Patient dissatisfaction directed at the provider**
- **Increasing 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 Price Transparency Tool (PTT)** ensures the hospital follows the CMS requirements for the upcoming and previous deadlines and allows the Patient to determine their out-of-pocket cost from a provider-based web portal.

The web-based tool includes detailed language and comprehensive support to better inform the User with regards to cost estimates they wish to obtain.

Learn more about the Price Transparency Tool by clicking on the document on this page, and by contacting your PARA Account Representative (see next page).

PARA'S PRICE TRANSPARENCY TOOL ADVANTAGES

Hospital price transparency is a requirement. And implementation can be a daunting task.

That's why PARA HealthCare Analytics has made it easy.

Here are 10 ways **PARA's Price Transparency** works for you.

1. **Ensures compliance** with the January 1, 2019 and January 1, 2021 CMS mandates for Price Transparency:
   - Post a listing of all services and prices available at the facility in a machine-readable format
   - Include payer specific reimbursement information for all services available at the facility

2. **Provides customized** and meaningful information for patients. Takes the guess work out of obtaining an estimate.

3. **Improves collections.** Patients will know their liability before the service is provided. They can even prepay!

4. **A Web-based solution.** Simple implementation. No software to install.

See A Demo By Clicking [The Button]

5. **Comprehensive tool** that pulls:
   - Top services at a facility
   - User's insurance information via Eligibility Checking
   - Registration information to return usage statistics readily available to the facility

6. **Highly customizable.**
   - The style and functionality of the tool to be directly embedded on the facility website
   - The services available on the Decision Tree and how they are presented (i.e. descriptions, categories)
   - The Prices that are presented (e.g., Average Line Charge, Average Package Charge, Average CDM Charge, etc.)
   - The programming to meet all expectations and functionality

7. **Always up to date** with the latest information for all users,with no additional work on behalf of the hospital once implemented.Fully serviced and managed on **PARA's** servers with all data and functionality accessible by the facility through the **PARA Data Editor**.

8. **Ongoing feature upgrades** and improvements that reflect changes in practice, technology, and services.

9. **Reporting capabilities** to review all activity on hospital website and what services are being shopped.

10. **Most cost-effective solution** in the industry. **PARA's** cost to deploy its solution is market competitive and in line with what CMS is saying healthcare organizations should pay for to implement a patient price estimator.

FOR DETAILS CONTACT OUR EXPERTS

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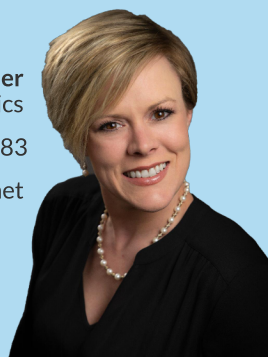

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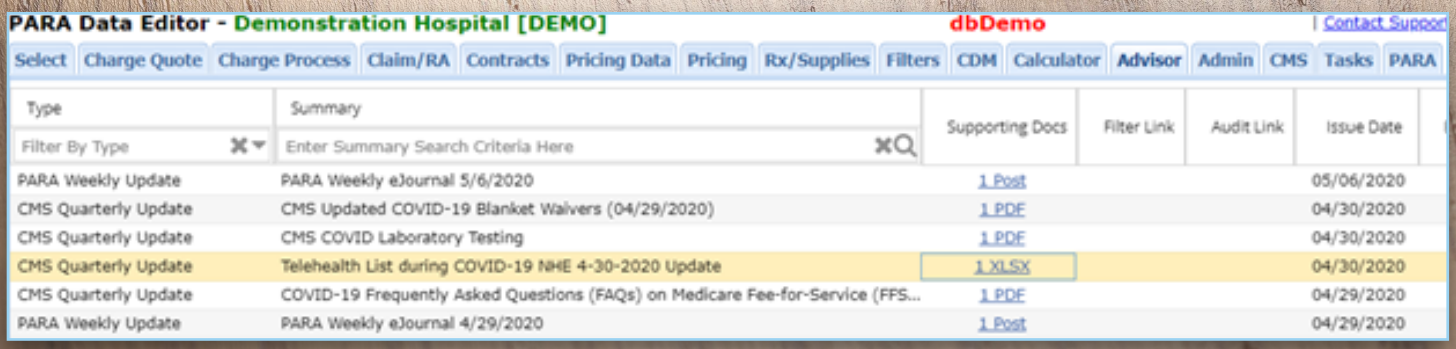
RHC AND FQHC EXPANDED FLEXIBILITIES DURING COVID-19 PHE

On April 30, 2020, CMS revised MLN Matters SE20016 (see Page 10 of this issue) that addresses new and expanded flexibilities during the COVID-19 Public Health Emergency (PHE), including telehealth.

For telehealth services between January 27, 2020 and June 30, 2020 –An RHC or FQHC practitioner, working within his/her scope of practice, may provide distant site telehealth services listed in the CMS telehealth codes.

Beginning March 1, 2020, RHCs and FQHCs providers may perform audio-only telephone evaluation and management services (CPT® 99441, 99442, and 99443) for an established patient, parent, or guardian.The services must be provided by a qualified healthcare professional and last at least 5 minutes.

The updated covered telehealth services list may be downloaded from the **Advisor** tab of the **PARA Data Editor:**



RHC AND FQHC EXPANDED FLEXIBILITIES DURING COVID-19 PHE

RHCs

- An RHC practitioner may provide services from the CMS telehealth list.However, the RHC clinic should not report the HCPCS codes from the list.Instead, they are required to report new HCPCS G2025 for any of the services listed on the telehealth spreadsheet

- For now, RHCs should append modifier CG to G2025, but only until July 1, 2020

- Medicare will pay claims with G2025 at the current all-inclusive rate (AIR) until July 1, 2020, when they will begin reprocessing claims at a fixed rate of $92.03. Because of the difference in payment rates, RHCs may consider holding claims G2025 until after July 1, 2020, to avoid processing refunds and adjustments

- RHCs should append modifier CS to waive coinsurance on G2025 for telehealth evaluation and management services related to COVID-19 testing. Because those claims will re-adjudicated after July 1, 2020,Medicare cautions RHCs not to collect the patient liability from those claims. RHCs may consider holding claims with modifier CS until after July 1, 2020, to avoid incorrectly billing patients

- Appending modifier 95 to G2025 is optional

- Beginning March 1, 2020, RHCs must report HCPCS G0071(Virtual communication), with or without other payable services.HCPCS G0071 provides payment for a variety of brief (5 minutes or more) virtual (non-face-to-face) communications between an RHC or FQHC provider and a Medicare beneficiary.

  Typically this would include digital evaluation and management services initiated by the patient and provided over a HIPAA-secure patient portal (typically reported as CPT® Codes 99421, 99422, 99423) or virtual communication services (typically reported as HCPCS G2012 and G2010).The payment rate during the COVID-19 PHE is $24.76

- Beginning July 1, 2020, RHCs should stop using modifier CG on G2025 telehealth claims

- RHCs that are provider-based to a hospital may increase inpatient bed capacity during the COVID-19 PHE to meet the needs of patients. To ensure the RHC will continue to be exempt from the national payment limit, for cost reports, CMS will use bed counts that were reported by the RHC prior to the COVID-19 PHE.

  Also, effective March 1, 2020, RHCs may, under a written plan of treatment, provide visiting RN or LPN services to beneficiaries in their homes where home health agencies have a shortage.HIPAA Eligibility Transaction System (HETS) must be checked to ensure the patient is not already receiving services under a home health plan of care

Jan 27, 2020 - June 30, 2020				
	Rev Code	HCPCS	Modifier(s)***	Payment
RHC *	052x	G2025	CG, 95 (optional)	AIR rate
Beginning July 1, 2020				
RHC	052x	G2025	95 (optional)	$ 92.03
** RHC Claims will be reprocessed by MAC at rate of $92.03 beginning July 1, 2020*				
**** For evaluation/management related to COVID-19 testing, report modifier -CS*				

RHC AND FQHC EXPANDED FLEXIBILITIES DURING COVID-19 PHE

FQHCs

For telehealth services that are also FQHC qualifying visits between January 27, 2020 and June 30, 2020 FQHCs must report three HCPCS codes for distant site telehealth services.

1. FQHC Prospective Payment System (PPS) payment codes:

HCPCS/CPT®
G0466 - FEDERALLY QUALIFIED HEALTH CENTER (FQHC) VISIT, NEW PATIENT; A MEDICALLY-NECESSARY, FACE-TO-FACE ENCOUNTER (ONE-ON-ONE) BETWEEN A NEW PATIENT AND A FQHC PRACTITIONER DURING WHICH TIME ONE OR MORE FQHC SERVICES ARE RENDERED AND INCLUDES A TYPICAL BUNDLE OF MEDICARE-COVERED SERVICES THAT WOULD BE FURNISHED PER DIEM TO A PATIENT RECEIVING A FQHC VISIT **Berenson-Eggers Type of Service: M1A** - OFFICE VISITS - NEW
G0467 - FEDERALLY QUALIFIED HEALTH CENTER (FQHC) VISIT, ESTABLISHED PATIENT; A MEDICALLY-NECESSARY, FACE-TO-FACE ENCOUNTER (ONE-ON-ONE) BETWEEN AN ESTABLISHED PATIENT AND A FQHC PRACTITIONER DURING WHICH TIME ONE OR MORE FQHC SERVICES ARE RENDERED AND INCLUDES A TYPICAL BUNDLE OF MEDICARE-COVERED SERVICES THAT WOULD BE FURNISHED PER DIEM TO A PATIENT RECEIVING A FQHC VISIT **Berenson-Eggers Type of Service: M1B** - OFFICE VISITS - ESTABLISHED
G0468 - FEDERALLY QUALIFIED HEALTH CENTER (FQHC) VISIT, IPPE OR AWV; A FQHC VISIT THAT INCLUDES AN INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE) OR ANNUAL WELLNESS VISIT (AWV) AND INCLUDES A TYPICAL BUNDLE OF MEDICARE-COVERED SERVICES THAT WOULD BE FURNISHED PER DIEM TO A PATIENT RECEIVING AN IPPE OR AWV **Berenson-Eggers Type of Service: M1B** - OFFICE VISITS - ESTABLISHED
G0469 - FEDERALLY QUALIFIED HEALTH CENTER (FQHC) VISIT, MENTAL HEALTH, NEW PATIENT; A MEDICALLY-NECESSARY, FACE-TO-FACE MENTAL HEALTH ENCOUNTER (ONE-ON-ONE) BETWEEN A NEW PATIENT AND A FQHC PRACTITIONER DURING WHICH TIME ONE OR MORE FQHC SERVICES ARE RENDERED AND INCLUDES A TYPICAL BUNDLE OF MEDICARE-COVERED SERVICES THAT WOULD BE FURNISHED PER DIEM TO A PATIENT RECEIVING A MENTAL HEALTH VISIT **Berenson-Eggers Type of Service: M1A** - OFFICE VISITS - NEW
G0470 - FEDERALLY QUALIFIED HEALTH CENTER (FQHC) VISIT, MENTAL HEALTH, ESTABLISHED PATIENT; A MEDICALLY-NECESSARY, FACE-TO-FACE MENTAL HEALTH ENCOUNTER (ONE-ON-ONE) BETWEEN AN ESTABLISHED PATIENT AND A FQHC PRACTITIONER DURING WHICH TIME ONE OR MORE FQHC SERVICES ARE RENDERED AND INCLUDES A TYPICAL BUNDLE OF MEDICARE-COVERED SERVICES THAT WOULD BE FURNISHED PER DIEM TO A PATIENT RECEIVING A MENTAL HEALTH VISIT **Berenson-Eggers Type of Service: M1B** - OFFICE VISITS - ESTABLISHED

2. The telehealth service code with modifier 95 HCPCS.

3. HCPCS G2025 with modifier 95:

Jan 27, 2020 - June 30, 2020				
	Rev Code	HCPCS	Modifier(s)***	Payment
FQHC qualified visits **	052x	G0466, G0467, G0468, G0469 or G0470	(none)	FQHC PPS Rate
	052x	Telehealth code	95	
	052x	G2025	95	
FQHC - (not qualified FQHC visit)	Hold claim until after July 1, 2020			
Beginning July 1, 2020				
FQHC	052x	G2025	95 (optional)	$ 92.03
*** FQHC Claims will be reprocessed by MAC at rate of $92.03 beginning July 1, 2020*				

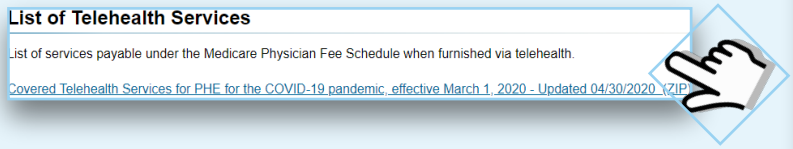
RHC AND FQHC EXPANDED FLEXIBILITIES DURING COVID-19 PHE

- As with RHCs, FQHCs will not be required to resubmit claims.CMS will pay the FQHCs at PPS rate until June 30, 2020, then will reprocess claims at the $92.03 rate beginning July 1, 2020
- Hold claims (do not bill) for telehealth services that are NOT also FQHC qualifying visits between January 27, 2020 and June 30, 2020. Beginning July 1, 2020, FQHCs may bill claims using G2025 (modifier 95 is not needed)
- For evaluation and management services that lead to COVID-19 testing, including those performed via telehealth, modifier CS should be appended to the service line to waive the beneficiary's coinsurance. **FQHCs should not collect coinsurances for these services**, which will be paid by Medicare when the claims are reprocessed in July
- Also, effective March 1, 2020, FQHCs may, under a written plan of treatment, provide visiting RN or LPN services to beneficiaries in their homes where home health agencies have a shortage. HIPAA Eligibility Transaction System (HETS) must be checked to ensure the patient is not already receiving services under a home health plan of care
- The provider must obtain consent from the beneficiary for all services, including telehealth and other non-face-to-face services. During the COVID-19 PHE, consent may be obtained at the same time the services are provided. They may be obtained by auxiliary staff working under the general supervision of the billing practitioner at the FQHC

On May 1, 2020, CMS updated its RHC/FQHC COVID-19 FAQ available using the link below:
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

A list of Telehealth Services is available for download using the link below:

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes


List of Telehealth Services

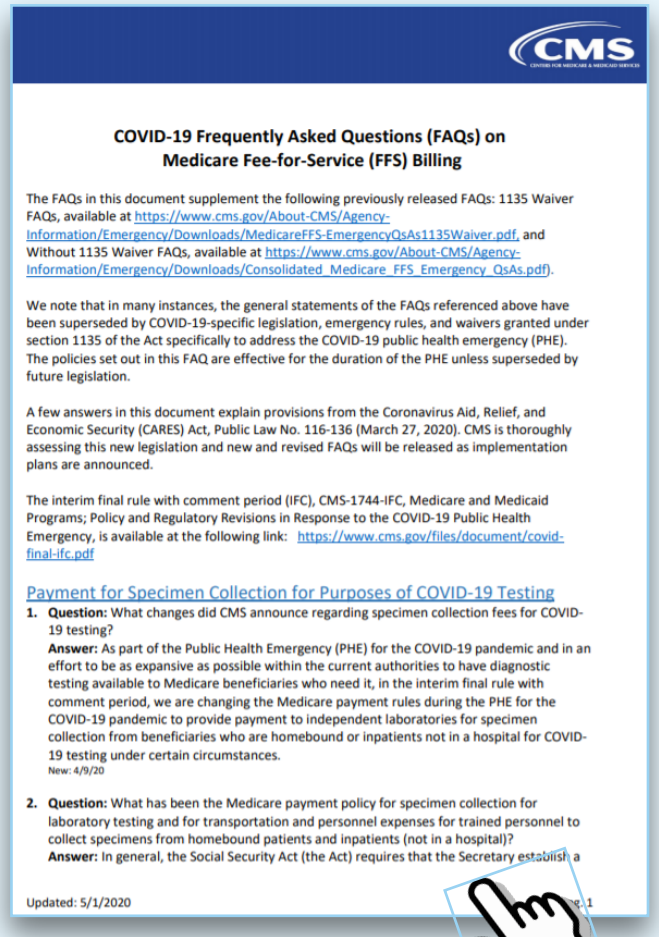
List of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.

Covered Telehealth Services for PHE for the COVID-19 pandemic, effective March 1, 2020 - Updated 04/30/2020 (ZIP)

The April 30, 2020 MLN may be found using the following link:

https://www.cms.gov/files/document/se20016.pdf


New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)


CMS

COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing

The FAQs in this document supplement the following previously released FAQs: 1135 Waiver FAQs, available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf, and Without 1135 Waiver FAQs, available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf).

We note that in many instances, the general statements of the FAQs referenced above have been superseded by COVID-19-specific legislation, emergency rules, and waivers granted under section 1135 of the Act specifically to address the COVID-19 public health emergency (PHE). The policies set out in this FAQ are effective for the duration of the PHE unless superseded by future legislation.

A few answers in this document explain provisions from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 (March 27, 2020). CMS is thoroughly assessing this new legislation and new and revised FAQs will be released as implementation plans are announced.

The interim final rule with comment period (IFC), CMS-1744-IFC, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, is available at the following link: https://www.cms.gov/files/document/covid-final-ifc.pdf

Payment for Specimen Collection for Purposes of COVID-19 Testing

1. **Question:** What changes did CMS announce regarding specimen collection fees for COVID-19 testing?
   Answer: As part of the Public Health Emergency (PHE) for the COVID-19 pandemic and in an effort to be as expansive as possible within the current authorities to have diagnostic testing available to Medicare beneficiaries who need it, in the interim final rule with comment period, we are changing the Medicare payment rules during the PHE for the COVID-19 pandemic to provide payment to independent laboratories for specimen collection from beneficiaries who are homebound or inpatients not in a hospital for COVID-19 testing under certain circumstances.
   New: 4/9/20
2. **Question:** What has been the Medicare payment policy for specimen collection for laboratory testing and for transportation and personnel expenses for trained personnel to collect specimens from homebound patients and inpatients (not in a hospital)?
   Answer: In general, the Social Security Act (the Act) requires that the Secretary establish a

Updated: 5/1/2020

New Guidance For FQHCs And RHCs

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)

MLN Matters Number: SE20016 Revised | Related Change Request (CR) Number: N/A

Article Release Date: April 30, 2020 | Effective Date: N/A

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

Note: We revised this article on April 30, 2020, to provide:

- **Additional claims submission and processing instructions**
- **Information on cost-sharing related to COVID-19 testing**
- **Additional information on telehealth flexibilities**
- **Information on provider-based RHCs exemption to the RHC payment limit**

All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) during the COVID-19 Public Health Emergency (PHE) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

To provide as much support as possible to RHCs and FQHCs and their patients during the COVID-19 PHE, both Congress and the Centers for Medicare & Medicaid Services (CMS) have made several changes to the RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and we will make additional discretionary changes as necessary to assure that RHC and FQHC patients have access to the services they need during the pandemic. For additional information, please see the RHC/FQHC COVID-19 FAQs at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

BACKGROUND

New Payment for Telehealth Services

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law. Section 3704 of the CARES Act authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system

CMS Medicare Learning Network

PARA
HealthCare Analytics

HEALTHCARE FINANCIAL RESOURCES

COVID-19

may, twenty-twenty

Special publication

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

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

The responses to COVID-19 are rapidly changing. That's why we've brought together a compilation of informative articles to simplify and clarify issues.

COVID-19 Resource Guide

Coronavirus

When President Trump declared a national emergency on March 13, 2020,CMS took action nationwide to aggressively respond to Cororavirus.

·You can read the blanket waivers for COVID-19 in the List of Blanket Waivers (PDF)UPDATED (4/9/20).

Secretary Azar used his authority in the Public Health Service Act to declare a public health emergency (PHE) in the entire United States on January 31, 2020 giving us the flexibility to support our beneficiaries, effective January 27, 2020

Get waiver & flexibility information

General information & updates:

- Coronavirus.gov is the source for the latest information about COVID-19 prevention, symptoms, and answers to common questions.
- USA.gov has the latest information about what the U.S. Government is doing in response to COVID-19.
- ·CDC.gov/coronavirus has the latest public health and safety information from CDC and for the overarching medical and health provider community on COVID-19.

Clinical & technical guidance:

For all clinicians

- CMS Dear Clinician Letter (PDF) (4/6/20)

For all health care providers

- CMS Non-Emergent, Elective Medical Services, and Treatment Recommendations (PDF)(4/6/20)
- CMS Adult Elective Surgery and Procedures Recommendations (PDF)(3/19/20)
- Fact sheet:Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge(3/30/20)
- Guidance memo - Exceptions and Extensions for Quality Reporting and Value-based Purchasing Programs (PDF)(3/27/20)

For health care facilities

- 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios (PDF)(4/13/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs): FAQs, Considerations for Patient Triage, Placement, Limits to Visitation and Availability of 1135 waivers(4/8/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Outpatient Settings: FAQs and Considerations(4/8/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and Psychiatric Residential Treatment Facilities (PRTFs)(4/8/20)
- Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Coronavirus Disease 2019 (COVID-19)UPDATED (4/8/20)
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) in Dialysis FacilitiesUPDATED (4/8/20)
- COVID-19 Long-Term Care Facility Guidance (PDF)(4/3/20)
- Accelerated and Advanced Payments Fact Sheet (PDF)(3/28/2020)
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes-REVISED (PDF)(3/13/20)
- Guidance for Use of Certain Industrial Respirators by Health Care Personnel(3/10/20)

COVID-19 Resource Guide

- Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) by Hospice Agencies(3/9/20)
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge(3/4/20)
- Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV)(2/6/20)

For Labs

- Frequently Asked Questions (FAQs), CLIA Guidance During the COVID-19 Emergency (PDF)(3/27/20)
- Notification to Surveyors of the Authorization for Emergency Use of the CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel Assay and Guidance for Authorized Laboratories(2/6/20)

For Programs of All-Inclusive Care for the Elderly (PACE) Organizations

- Frequently Asked Questions from the PACE Community (PDF)(4/14/20)
- Guidance for PACE Organizations Regarding Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) (PDF)(3/17/20)

Billing And Coding Guidance:

- Frequently Asked Questions to Assist Medicare Providers (PDF)UPDATED (4/11/20)
- CMS Dear Clinician Letter (PDF)(4/6/20)
- Fact sheet: Expansion of the Accelerated and Advance Payments Program for Providers and Suppliers During COVID-19 Emergency (PDF)(3/30/20)
- Fact sheet:Medicare Coverage and Payment Related to COVID-19 (PDF)UPDATED (3/23/20)
- Fact sheet:Medicare Telemedicine Healthcare Provider Fact Sheet(3/17/20)
- Medicare Telehealth Frequently Asked Questions(3/17/20)
- MLN Matters article:Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (PDF)(3/17/20)
- Frequently Asked Questions about Medicare Fee-for-Service Emergency-Related Policies and Procedures**Without**an 1135 Waiver (PDF)(3/16/20)
- Frequently Asked Questions about Medicare Fee-for-Service Emergency-Related Policies and Procedures**With**an 1135 Waiver (PDF)(3/16/20)
- Fact sheet:Medicare Administrative Contractor (MAC) COVID-19 Test Pricing (PDF)(3/13/20)
- Fact sheet:Medicaid and CHIP Coverage and Payment Related to COVID-19 (PDF)(3/5/20)COVID-19: New ICD-10-CM Code and Interim Coding Guidance(2/20/20)

For Health Care Facilities

- 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios (PDF)(4/13/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs): FAQs, Considerations for Patient Triage, Placement, Limits to Visitation and Availability of 1135 waivers(4/8/20)
- Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Outpatient Settings: FAQs and Considerations(4/8/20)

COVID-19 Resource Guide

Survey And Certification Guidance:

- Clinical Laboratory Improvement Amendments (CLIA) Laboratory Guidance During COVID-19 Public Health Emergency(3/27/20)
- Prioritization of Survey Activities(3/23/20)
- Frequently Asked Questions for State Survey Agency and Accrediting Organization Coronavirus Disease 2019 (COVID-19) (PDF)(3/10/20)
- Frequently Asked Questions and Answers on EMTALA (PDF)(3/9/20)
- Suspension of Survey Activities(3/4/20)

Coverage Guidance:

- Frequently Asked Questions to Assist Medicare Providers (PDF)UPDATED (4/11/20)
- VIDEO-MLN Medicare Coverage and Payment of Virtual Services(4/10/20)
- CMS Dear Clinician Letter (PDF)(4/6/20)
- Long-Term Care Nursing Homes Telehealth and Telemedicine Toolkit (PDF)(3/27/20)
- Fact sheet:Medicare Coverage and Payment Related to COVID-19 (PDF)UPDATED (3/23/20)
- General Telemedicine Toolkit (PDF)(3/20/20)
- End-Stage Renal Disease (ESRD) Provider Telehealth and Telemedicine Toolkit (PDF)(3/20/20)
- FAQs on Catastrophic Plan Coverage and the Coronavirus Disease 2019 (COVID-19) (PDF)(3/19/20)
- Fact sheet:Medicare Telemedicine Healthcare Provider Fact Sheet(3/17/20)
- Medicare Telehealth Frequently Asked Questions(3/17/20)
- FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19) (PDF)(3/13/20)
- Guidance to help Medicare Advantage and Part D Plans Respond to COVID-19 (PDF)(3/10/20)
- Fact sheet:Medicaid and CHIP Coverage and Payment Related to COVID-19 (PDF)(3/5/20)
- Fact sheet:Individual and Small Group Market Insurance Coverage (PDF)(3/5/20)

Provider Enrollment Guidance:

- Guidance for Processing Attestations from Ambulatory Surgery Centers (ASCs) Temporarily Enrolling as Hospitals During the COVID-19 Public Health Emergency(4/3/20)
- Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)-UPDATED (3/30/20) (PDF)

Medicaid & CHIP Guidance:

- Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 Frequently Asked Questions (FAQs)(4/15/20)
- Federal Medical Percentage Map (FMAP)&Families First Coronavirus Response Act – Increased FMAP FAQs3/27/20
- State Medicaid Director Letter (SMDL) #20-002 with New Section 1115 Demonstration Opportunity to Aid States With Addressing the Public Health Emergency(3/22/20)
- Section 1135 Waiver Checklist(3/22/20)
- Section 1915 Waiver, Appendix K Template(3/22/20)
- State Plan Flexibilities(3/22/20)

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, May 14, 2020

News

·IPPS and LTCH PPS: FY 2021 Proposed Rule

·Medicare FFS 2nd Level Appeals: Submission Options

Events

·COVID-19: Office Hours Call — May 14

·COVID-19: Lessons from the Front Lines Call — May 15

MLN Matters® Articles

·Medicare Clarifies Recognition of Interstate License Compacts

·Extension of Payment for Section 3712 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act)

·International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2020 Update

·Updates to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) to Correct the Adjustment Process

·Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised

Publications

·How to Use the Medicare Coverage Database — Revised

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There were TWO new or revised MedLearns released this week.

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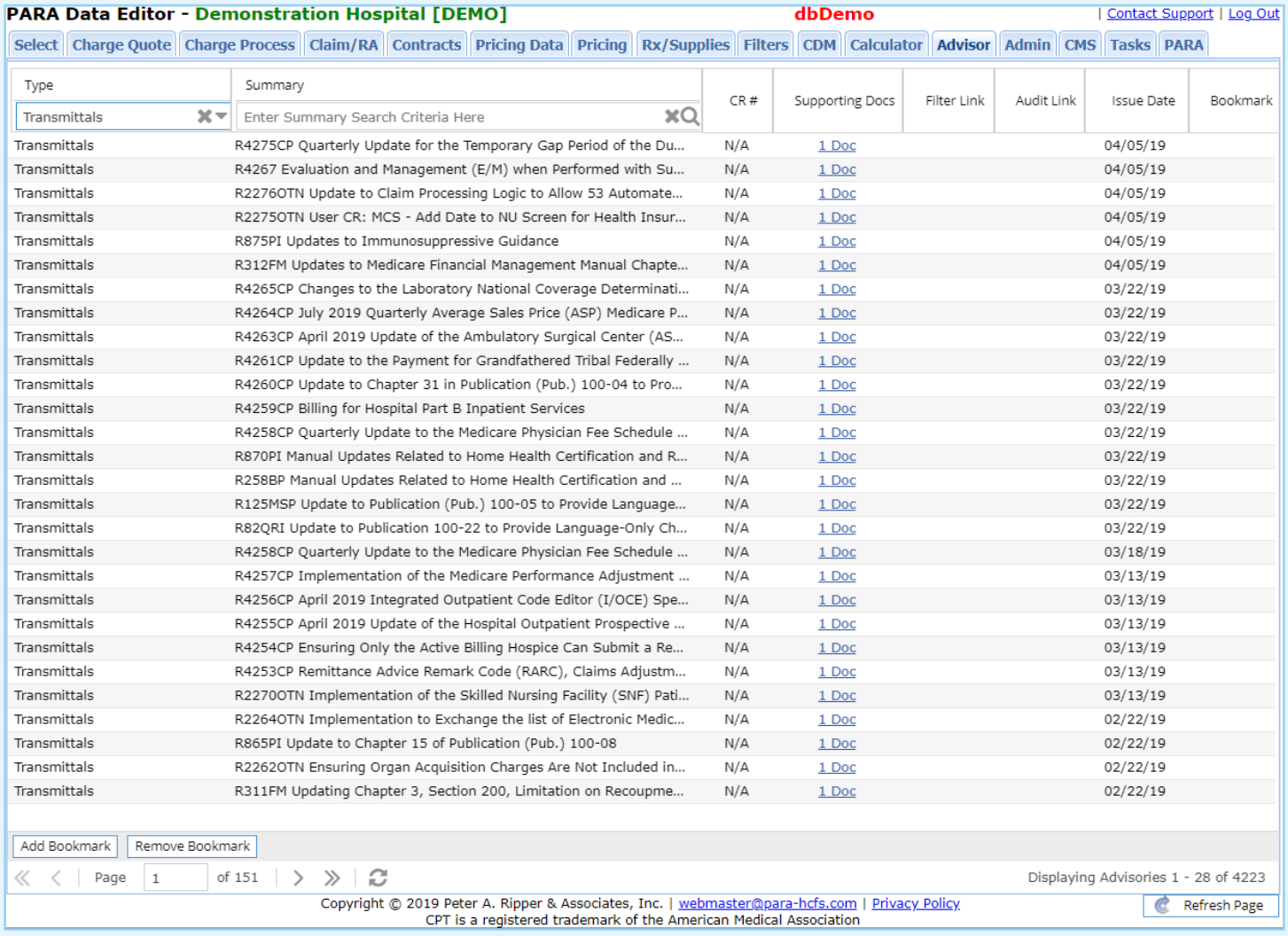

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Transmittals	R4275CP Quarterly Update for the Temporary Gap Period of the Du...	N/A	1 Doc			04/05/19	
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Transmittals	R4254CP Ensuring Only the Active Billing Hospice Can Submit a Re...	N/A	1 Doc			03/13/19	
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Transmittals	R2264OTN Implementation to Exchange the list of Electronic Medic...	N/A	1 Doc			02/22/19	
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KNOWLEDGE • RESOURCES • TRAINING

Manual Update to Pub. 100-04, Chapter 38, to Remove Identification of Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico Section

MLN Matters Number: MM11778 | Related Change Request (CR) Number: 11778

Related CR Release Date: May 15, 2020 | Effective Date: June 16, 2020

Related CR Transmittal Number: R10135CP | Implementation Date: June 16, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors for services to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

This article informs you that Medicare will remove Section 20 (and all of its subsections) of the Medicare Claims Processing Manual (Identification of Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico). The key impact is that modifier CS is no longer to be used to denote services related to the 2010 oil spill.

ADDITIONAL INFORMATION

The official instruction, CR 11778, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10135CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Therapy Codes Update

MLN Matters Number: MM11791 | Related Change Request (CR) Number: 11791

Related CR Release Date: May 15, 2020 | Effective Date: March 1, 2020

Related CR Transmittal Number: R10139OTN | Implementation Date: July 6, 2020

PROVIDER TYPES 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

This article informs you of updates to the list of codes that sometimes or always describe therapy services. The additions to the therapy code list reflect those made in the Calendar Year (CY) 2020 for the COVID-19 Public Health Emergency (PHE). Please make sure your billing staffs are aware of these changes.

BACKGROUND

Section 1834(k)(5) of the Social Security Act (the Act) requires all claims for outpatient rehabilitation therapy services and all Comprehensive Outpatient Rehabilitation Facility (CORF) services be reported using a uniform coding system. The CY 2020 Current Procedural Terminology (CPT) and Level II HCPCS are the coding systems used for reporting these services. The therapy code listing is on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

CR 11791 implements policies reflective of those related to the interim final rule with comment (IFC) entitled Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 PHE (CMS-1744-IFC); and the IFC-entitled Medicare and Medicaid Programs Additional Policy and Regulatory Revisions in Response to the COVID-19 PHE (CMS-5531-IFC); and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). CR 11791 updates the therapy code list and associated policies effective March 1, 2020, for the duration of the COVID-19 PHE.

CMS is designating the below listed codes we've collectively termed as Communications Technology-Based Services (CTBS) as "sometimes therapy," to permit physicians and Non-Physician Practitioners (NPPs), including nurse practitioners, physician assistants, and clinical nurse specialists to provide these services outside a therapy plan of care when appropriate.

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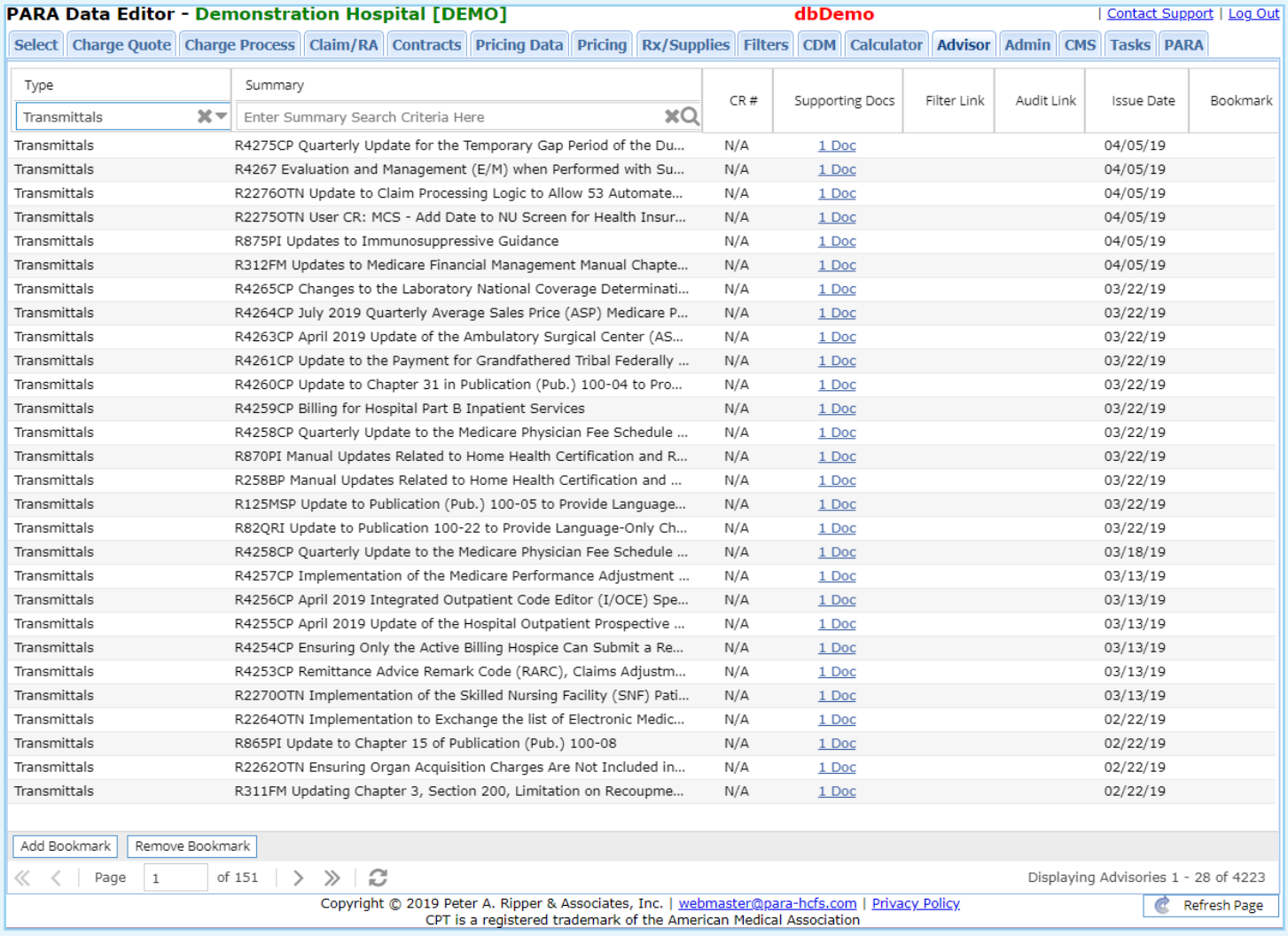

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The link to this Transmittal R10140CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10140	**Date: May 15, 2020**
	Change Request 11797

SUBJECT: Updates in the Fiscal Intermediary Shared System (FISS) Inpatient Provider Specific Files (PSF)

I. SUMMARY OF CHANGES: This Change Request (CR) describes changes to payment polices initiated under CR 11707 (Updates in the Fiscal Intermediary Shared System (FISS) Inpatient and Outpatient Provider Specific Files (PSF)), for Skilled Nursing Facilities (SNF), Inpatient Psychiatric Facilities (IPF), and Inpatient Rehabilitation Facilities (IRF) to be implemented in the 2021 final rules. Instructions to the Medicare Administrative Contractors (MACs) will be provided in the corresponding recurring CRs.

EFFECTIVE DATE: October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/190.17.1 – Inputs/Outputs to PRICER
R	6/30.4.1 - Input/Output Record Layout

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 R10135CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10135	Date: May 15, 2020
	Change Request 11778

SUBJECT: Manual Update to Pub. 100-04, Chapter 38, to Remove Identification of Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico Section

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to remove manual section, 20- Identification of Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico, and subsections 20.1 and 20.2 from Pub.100-04, Chapter 38 Emergency Preparedness Fee-For-Service Guidance.

EFFECTIVE DATE: June 16, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 16, 2020

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	38/Table of Contents
D	38/20 - Identification of items or Services Related to the 2010 Oil Spill in the Gulf of Mexico/20.1 - Modifier CS/20.2 - Condition Code BP

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

Business Requirements
Manual Instruction

The link to this Transmittal R10139OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10139	**Date: May 15, 2020**
	Change Request 11791

SUBJECT: Therapy Codes Update

I. SUMMARY OF CHANGES: This Change Request (CR) updates the list of codes that sometimes describe therapy services. The additions to the therapy code list reflect those made in the Calendar Year (CY) 2020 for the COVID-19 public health emergency (PHE).

EFFECTIVE DATE: March 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2020 – August 7, 2020 date for the MACs

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IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R10132PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10132	**Date: May 15, 2020**
	Change Request 11695

SUBJECT: Revising Subsection 3.2.5, Targeted Probe and Educate (TPE), in Chapter 3 of Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise subsection 3.2.5, Targeted Probe and Educate (TPE), in Chapter 3 of of Pub. 100-8 to add additional detail regarding next steps after referral to CMS.

EFFECTIVE DATE: June 16, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 16, 2020

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.2/3.2.5/Targeted Probe and Educate (TPE)

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IV. ATTACHMENTS:

Business Requirements
Manual Instruction

The link to this Transmittal R10141DEMO

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10141	**Date: May 15, 2020**
	Change Request 11419

SUBJECT: Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 1: Provider, Beneficiary and Procedure Code Files to Support Model Implementation

I. SUMMARY OF CHANGES: The Innovation Center has secured approval for the Primary Care First (PCF) and Serious Illness Patient (SIP) Models, demonstrations testing alternative payment model and technical support to primary care practices. PCF is designed to test whether changing how Medicare pays for primary care can lead to reductions in acute hospital utilization and lower total cost of care while preserving or improving quality. SIP is designed to include practices that specialize in caring for complex, chronically ill patient populations. In addition to supporting enhanced care delivery for practices' current patients, the SIP model aims to extend the reach of these advanced practices by enabling them to proactively engage sick and unmanaged Medicare fee-for-service (FFS) beneficiaries who lack a primary care practitioner and/or effective care coordination.

The purpose of this CR is to implement Flat Visit Fee (FVF) and One-Time SIP Payment, and deny billing Chronic Care Management HCPCS Codes. PCF and SIP participating providers submitting a claim eligible under the FVF will have each claim adjusted to a national base total allowed amount of $40.82. Once each claim has been adjusted to the national base rate of $40.82 each one will be adjusted according to Geographic Adjustment Factors (GAFs) from the Physician Fee Schedule (PFS). Below are some other important facts about the FVF:

- Includes Coinsurance
- Waives the 15% reduction to Fee-For-Service Claims submitted by Non-Physician Providers
- Tied to specific HCPCS Codes found in Appendix A

SIP providers must proactively engage with sick and unmanaged Medicare FFS beneficiaries showing an absence of effective care coordination. In order to receive the One-Time SIP Payment, SIP providers shall submit a G-Code HCPCS Code G2020 after rendering services from the first visit with each attributed Medicare FFS beneficiary. The One-time SIP payment is will be set to a total allowed amount of $331.63 for each beneficiary with coinsurance and deductible waived. Below are some additional facts for this payment:

- Includes the 15% reduction to Fee-For-Service Claims submitted by Non-Physician Providers
- Not geographically adjusted
- HCPCS Code G2020
- G-Code may only be billed once per Medicare FFS Beneficiary per lifetime
- HCPCS Codes from Appendix A with same date of service as HCPCS Code G2020 are ineligible and will be denied

PCF and SIP providers are receiving non-claims based payments that cover providing services under the Chronic Care Management (CCM) and some Home Health codes. In order to prevent duplicative payments, PCF and SIP are prohibited from billing CCM and some Home Health codes listed in Appendix B on any of their attributed beneficiaries. CMS will deny claims or claim lines with Appendix B HCPCS Codes for

The link to this Transmittal R10137CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10137	**Date: May 15, 2020**
	Change Request 11787

SUBJECT: Indian Health Services (IHS) Hospital Payment Rates for Calendar Year 2020

I. SUMMARY OF CHANGES: Annual update of Indian Health Services (IHS) payment rates for calendar year 2020. The attached Recurring Update Notification applies to Chapter 19, Section 100.3.4, 100.4.2, and 100.5.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 17, 2020

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10138PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10138	**Date: May 15, 2020**
	Change Request 11546

SUBJECT: Moving Chapter 15 (Medicare Enrollment) Manual Instructions in Publication (Pub.) 100-08 to Chapter 10 (Medicare Enrollment)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to reorganize and move information in Chapter 15 to Chapter 10 of Pub. 100-08. In order to accomplish this task, this CR is deleting approximately eighty-two sections from chapter 15 and creating nine (9) new sections in chapter 10. This CR organizes the sections into more manageable content units that will be easily understood by the providers/suppliers. A crosswalk document is included as a reference point to provide easier navigation of the information.

EFFECTIVE DATE: June 16, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 16, 2020

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CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10143	**Date: May 14, 2020**
	Change Request 11504

Transmittal 10103, dated May 8, 2020, is being rescinded and replaced by Transmittal 10143, dated, May 14, 2020 to remove "For claims processed on and after this date" in the Effective Date. All other information remains the same.

SUBJECT: Editing Update for Abdominal Aortic Aneurism and Screening Pap Smears and Pelvic Examinations

I. SUMMARY OF CHANGES: This Change Request modifies existing frequency editing for AAA and Screening Pap Smears and Pelvic Examinations to ensure claims are denied at a line level.

EFFECTIVE DATE: October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020

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IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R10136CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10136	**Date: May 15, 2020**
	Change Request 11782

SUBJECT: Update to the (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.9 - Fee Schedule Administration and Coding Requirements

I. SUMMARY OF CHANGES: This Change Request (CR) will update the Internet Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, Section 20.9 - Fee Schedule Administration and Coding Requirements.

EFFECTIVE DATE: June 16, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 16, 2020

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	23/20.9 - National Correct Coding Initiative (NCCI)
R	23/20.9.1 - Correct Coding Modifier Indicators and HCPCS Codes Modifiers
R	23/20.9.1.1 - Instructions for Codes with Modifiers (A/B MACs (B) Only)
R	23/20.9.3 - Appeals
R	23/20.9.3.1- Procedure-to-Procedure Edits
R	23/20.9.3.2- Medically Unlikely Edits
D	23/20.9.6 - Correct Coding Edit (CCE) File Record Format

III. FUNDING:
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- Recent Legacy Conversion
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- Net A/R Days Greater Than 45

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