May 5, 2021

PARA Weekly eJOURNAL

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FAST LINKS

DEVICE DEPENDENT PROCEDURE 19285

Q. Can you help us understand the need for a device code due to a new coding edit for CPT® 19285?

A. **Answer:** CPT® 19285 is new to the list of "device intensive" procedures under Medicare OPPS in 2021.

It is puzzling that Medicare added 19285 to the list of device-intensive procedures this year. That list represents HCPCS which are typically billed together with a device code, and furthermore the cost of the device represents more than 30% of the calculated APC reimbursement for the procedure.

According to our Medicare claims data, in the first 6 months of 2020, only 27.5% of the 5,019 outpatient claims submitted to Medicare for CPT® 19285 listed implant code A4648 TISSUE MARKER, IMPLANTABLE, ANY TYPE, EACH. Another 3.4% of claims reported a brachytherapy seed, C2638. The rest of the claims reported no HCPCS-coded device at all.

Returning to the problem at hand – First, we presume no brachytherapy seed was implanted, as the C-code for a seed would have satisfied the edit. If a tissue marker was implanted, consider adding A4648 to the claim under revenue code 0278. If nothing was implanted, it's possible that the procedure code 19285 is incorrect. (19285 - PLACEMENT OF BREAST LOCALIZATION DEVICE(S) (EG, CLIP, METALLIC PELLET, WIRE/NEEDLE, RADIOACTIVE SEEDS), PERCUTANEOUS; FIRST LESION, INCLUDING ULTRASOUND GUIDANCE.)

As an alternative, the hospital may report modifier CG on the procedure code 19285. Over a year ago, Medicare introduced modifier CG in the October, 2019 Integrated Outpatient Code Editor update file. The guidance instructed hospitals to append modifier CG – "Policy criteria applied" – when reporting a device-dependent outpatient procedure which did not require a device. Here's the pertinent excerpt from the Medicare Claims Processing Manual:

Medicare Claims Processing Manual (cms.gov)

61.2.1 – Bypass Edit Modifier "CG" for Claims on Which Specified Procedures are to be Reported With Device Codes

(Rev.4513, Issued: 02-04-2020, Effective: 01-01- 2020, Implementation: 01-06-2020)

For certain device-intensive procedures, providers may bypass the device edit requiring at least one device HCPCS code for the procedure. For situations where no device was performed with certain device-intensive procedures, providers may bypass the edit by reporting modifier "CG".

FRVU AND NFRVU

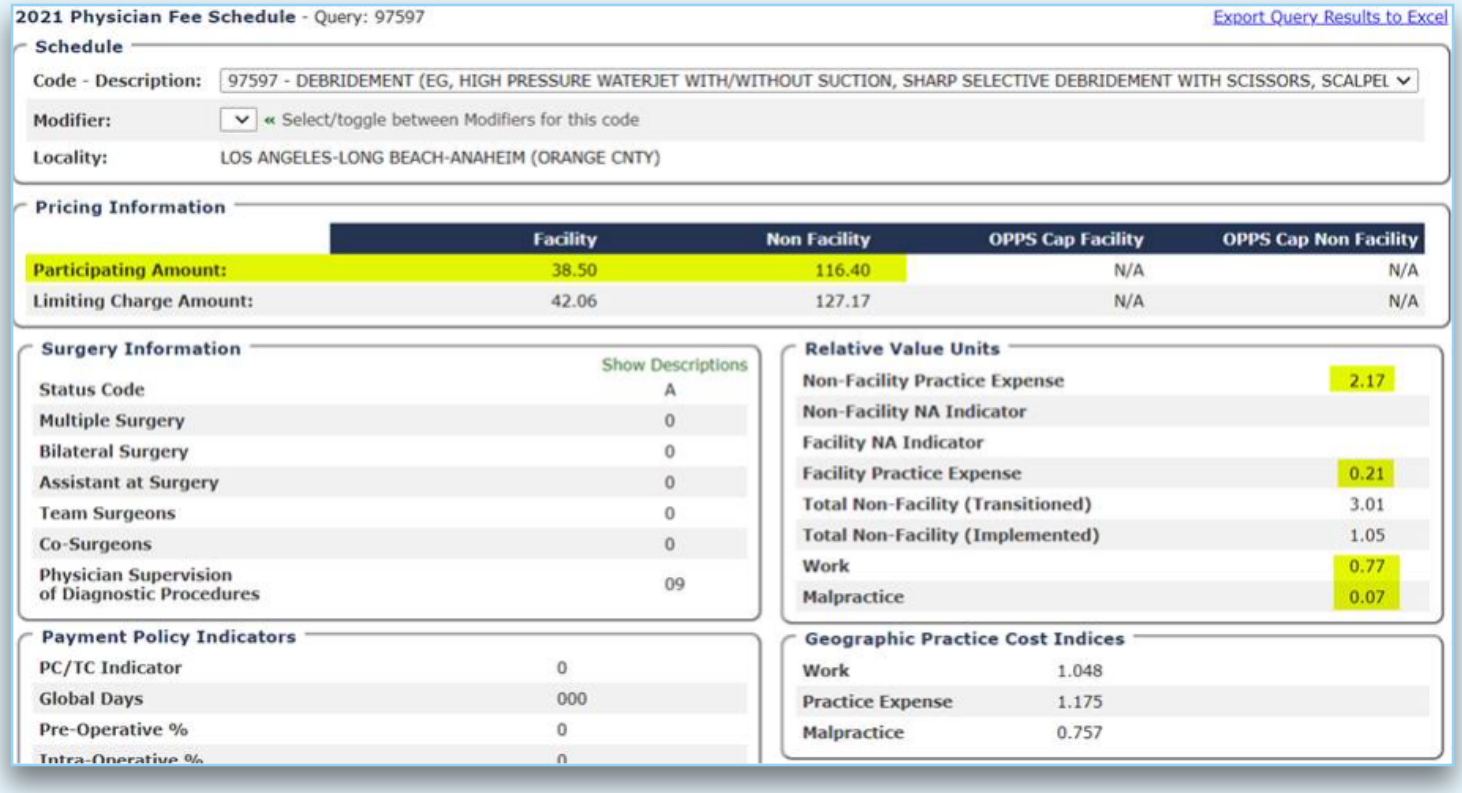
Q. In my CPT® book there are two RVUs; an FRVU and an NFRVU. Most of the time these are the same, but when they are not, which one should I go by?

A. **Answer:** You didn't say what your objective is in using the RVU value -- some hospitals use it for setting prices for professional fees, some may use RVU's for calculating provider productivity, which is then tied to the salary or other rate of payment for the employed provider. In either case, it's important to pick up the correct RVU value based on whether the service will be performed in the facility or non-facility setting.

For many, but not all physician service codes, the Medicare Physician Fee schedule (MPFS) offers an RVU value used in calculating reimbursement in the facility setting (FRVU) and in the non-facility setting (NFRVU.) The RVU value is multiplied against a conversion factor to calculate the total "allowable" reimbursement for a professional fee claim under the Medicare Physician Fee Schedule (MPFS.)

There are three components to the total RVU's used calculate reimbursement for a code: physician work, practice expense, and malpractice liability. The Practice Expense component is always lower in the facility setting than the non-facility setting. The practice expense RVU is reduced in the facility setting because the facility will submit a separate claim for its service, so the reimbursement to the physician will not cover the cost of the environment of care. In the non-facility setting, the only claim for the entire service – including the cost of the environment of care – is represented on the professional fee claim, consequently the rate of reimbursement is higher as reflected in the higher non-facility RVU.

For example, MPFS reimbursement rates for a debridement procedure, 97597 differs in the facility or non-facility setting. The PARA Data Editor Calculator report for Professional Fees will reveal the RVUs for facility and non-facility Settings – the work and malpractice liability is the same in either setting, only the Practice Expense differs:



2021 Physician Fee Schedule - Query: 97597 — Export Query Results to Excel

Schedule

Code - Description:	97597 - DEBRIDEMENT (EG, HIGH PRESSURE WATERJET WITH/WITHOUT SUCTION, SHARP SELECTIVE DEBRIDEMENT WITH SCISSORS, SCALPEL
Modifier:	« Select/toggle between Modifiers for this code
Locality:	LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY)

Pricing Information

	Facility	Non Facility	OPPS Cap Facility	OPPS Cap Non Facility
Participating Amount:	38.50	116.40	N/A	N/A
Limiting Charge Amount:	42.06	127.17	N/A	N/A

Surgery Information (Show Descriptions)

Status Code	A
Multiple Surgery	0
Bilateral Surgery	0
Assistant at Surgery	0
Team Surgeons	0
Co-Surgeons	0
Physician Supervision of Diagnostic Procedures	09

Relative Value Units

Non-Facility Practice Expense	2.17
Non-Facility NA Indicator	
Facility NA Indicator	
Facility Practice Expense	0.21
Total Non-Facility (Transitioned)	3.01
Total Non-Facility (Implemented)	1.05
Work	0.77
Malpractice	0.07

Payment Policy Indicators

PC/TC Indicator	0
Global Days	000
Pre-Operative %	0
Intra-Operative %	0

Geographic Practice Cost Indices

Work	1.048
Practice Expense	1.175
Malpractice	0.757

FRVU AND NFRVU

The RVUs are directly tied to the professional fee payment rate, facility or non-facility. A professional fee claim (CMS1500/837p) is paid under the MPFS is determined by the place of service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, non-physician practitioner (NPP) or other supplier. In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or non-facility payment rate is paid.

However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred.

A Method II CAH may report employed physician services on an outpatient hospital claim (UB04/837i, TOB 85X) under a professional fee revenue code. Reimbursement for CAH Method II pro fees are calculated using the facility RVU rate, since the 851 Type of Bill is an outpatient hospital claim.

Finally, we should mention that Medicare adjusts the three RVU component values (practice expense, physician work, and malpractice liability), based on "Geographic Practice Cost Indices", often referred to as GPCI ("Gypsy") adjustments. These adjustments take into consideration the cost of practicing medicine in different areas of the country.

UPDATE

COVID-19 UPDATE

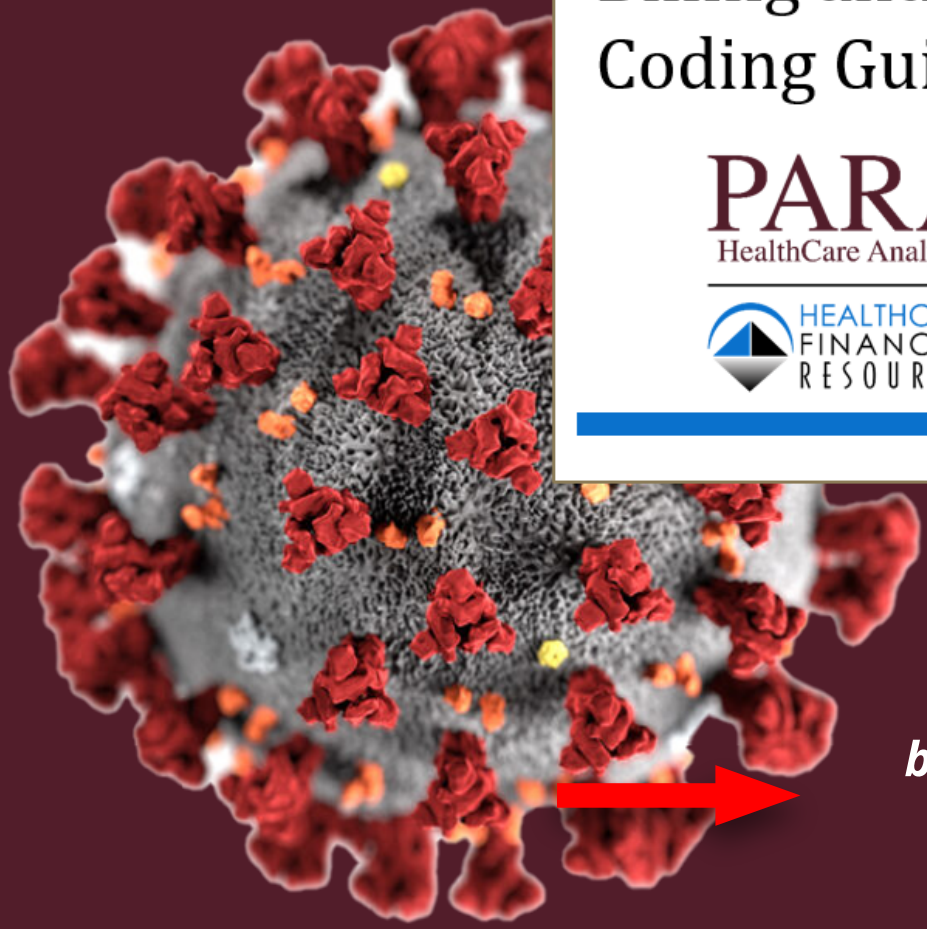
PARA HealthCare Analytics *continues to update COVID-19 coding and billing information based on frequently changing guidelines and regulations from CMS and payers. All coding must be supported by medical documentation.*

Updated April 27, 2021

Comprehensive COVID-19 Billing and Coding Guide

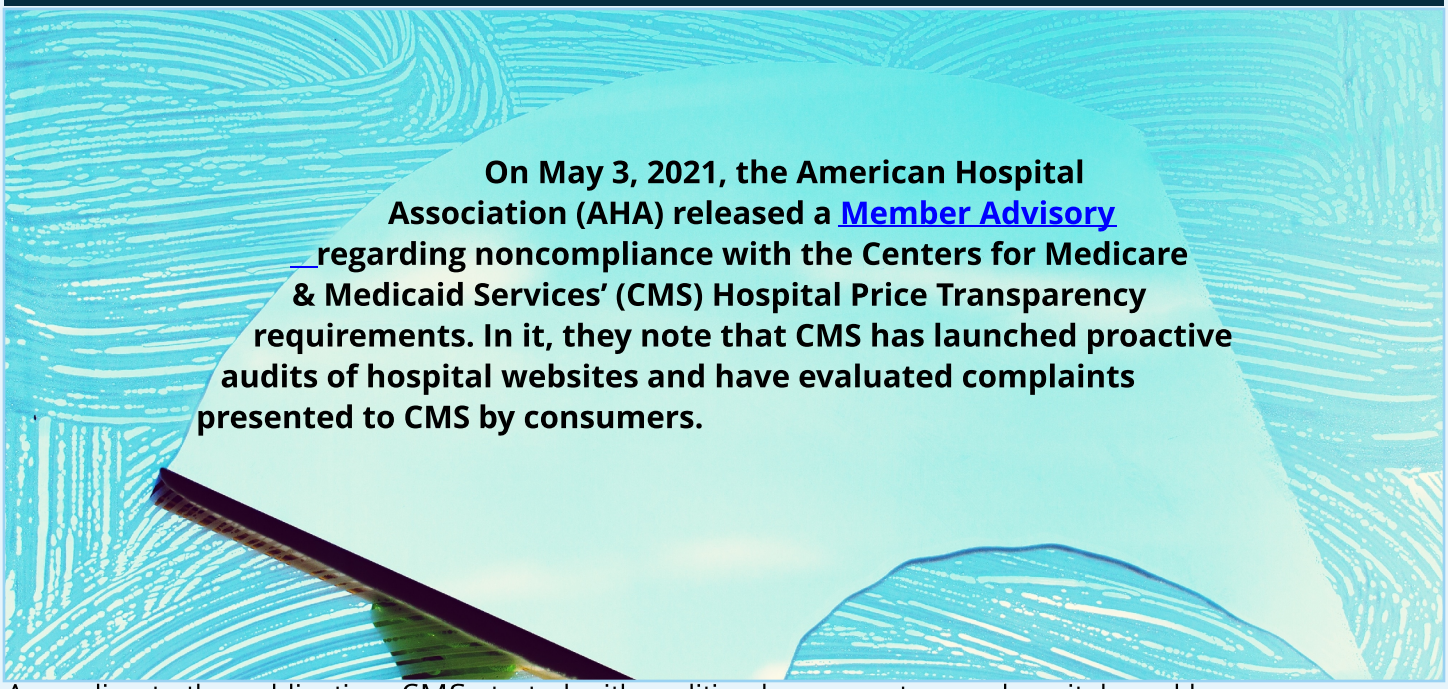
PARA
HealthCare Analytics

HEALTHCARE FINANCIAL RESOURCES



Download the updated Guidebook by clicking here.

CMS PRICE TRANSPARENCY COMPLIANCE UPDATE



According to the publication, CMS started with auditing larger acute care hospitals and have now expanded their examination of random hospitals.The first set of warning letters were issued the week of April 19th.However, CMS has indicated that they will not announce the list of hospitals that have received warning letters but will publish the identities of the hospitals that remain non-compliant and receive a monetary penalty if they have not addressed the issues within 90 days.

PARA HealthCare Analytics, an **HFRI Company**, is among the leaders in supporting hospitals in achieving readiness for CMS Price Transparency regulations, which will help consumers make more informed healthcare purchasing decisions. To ensure consumers will be able to browse for healthcare services in the same way they shop for other goods and services online, PARA has developed robust and accurate pricing capabilities for area healthcare consumers. The **PARA** solution includes a patient-facing estimator that delivers user-friendly, procedure-level estimates reflecting patients' specific coverage limits and is updated quarterly for the facility.

As a reminder, the CMS Hospital Price Transparency rule requires that hospitals publish detailed pricing information online to help consumers make accurate cost comparisons for a range of treatments and procedures.

The rule contains two types of price transparency requirements:

- Hospitals must post their entire array of standard charges online in a machine-readable file that is easily accessible from their public website.
- Hospitals must publish a document listing pricing for 300 specific shoppable healthcare services. Of these 300 items, 70 have been pre-defined by CMS, while the remaining 230 can be selected at the discretion of the hospital.

For both requirements, a range of different price categories must be shown, including gross charges, payer-specific negotiated rates, self-pay discounted rates, and de-identified minimum and maximum negotiated charges. The files also must contain any ancillary charges that are customarily included for the specific shoppable service, such as the costs associated with additional related procedures, tasks, allied services, supplies, or drugs, as well as any professional fees billed separately from the facility bill.

CMS PRICE TRANSPARENCY COMPLIANCE UPDATE

These requirements present challenges when it comes the sheer data mining and payer contract analytics required to deliver on the mandates. **PARA's** payer contract models accommodate a variety of settlement methodologies by patient type including MS-DRG, APR-DRG, EAPG, ASC Levels, APC packaging, and percent of charge, among others.

For a typical hospital with a 10,000-line chargemaster, seven patient types, and 20 payer contracts, this could mean 1.4M calculations needed to fulfill the mandate. According to an HFMA Article on the topic, this detailed approach could cost a hospital several hundred thousand dollars to contract with a consulting firm.

However, **PARA's Price Transparency Tool**, which uses the actual payer contract language as outlined in the CMS requirements to make those millions of calculations, costs under $30,000 in the first year, with nominal (under $3,000) quarterly maintenance fees thereafter.It is the most cost-effective and comprehensive solution out there today.

PARA has done the heavy lifting to deliver the best solution possible for our Hospital Partners.

Consumers expect to shop for healthcare the same way they shop for other goods and services and healthcare providers must be ready to meet that need.

Therefore, **PARA HealthCare Analytics**, has partnered with hospitals across the nation to empower them in providing this required information in a consumer-friendly, intuitive manner.

The team at **PARA HealthCare Analytics** believes that price transparency and Patient Price Estimators are a useful and important component of healthcare consumerism and have spent the past year preparing for the release of these requirements.In speaking with hospital associations, clients, and business vendor groups, we are finding that we are one of the only vendors who can completely satisfy, to the spirit and letter of the law, both CMS requirements in a fully customizable manner.

According to Peter Ripper, CEO of **PARA**, "The President's Executive Order in June 2019 promoted increased availability of meaningful pricing information for Patients. The key word here is meaningful. Therefore, since the release of the CMS requirements, we've focused on creating an approach to these obligations that would lessen confusion for patients and support the hospital in fulfilling the mandates.With a healthcare environment riddled with various pressures including thin operating margins, health plan competition, and a shortage of resources due to a pandemic, **PARA** has done the heavy lifting to deliver the best solution possible for our Hospital Partners."

To find out more about our solution, please contact one of our experts.

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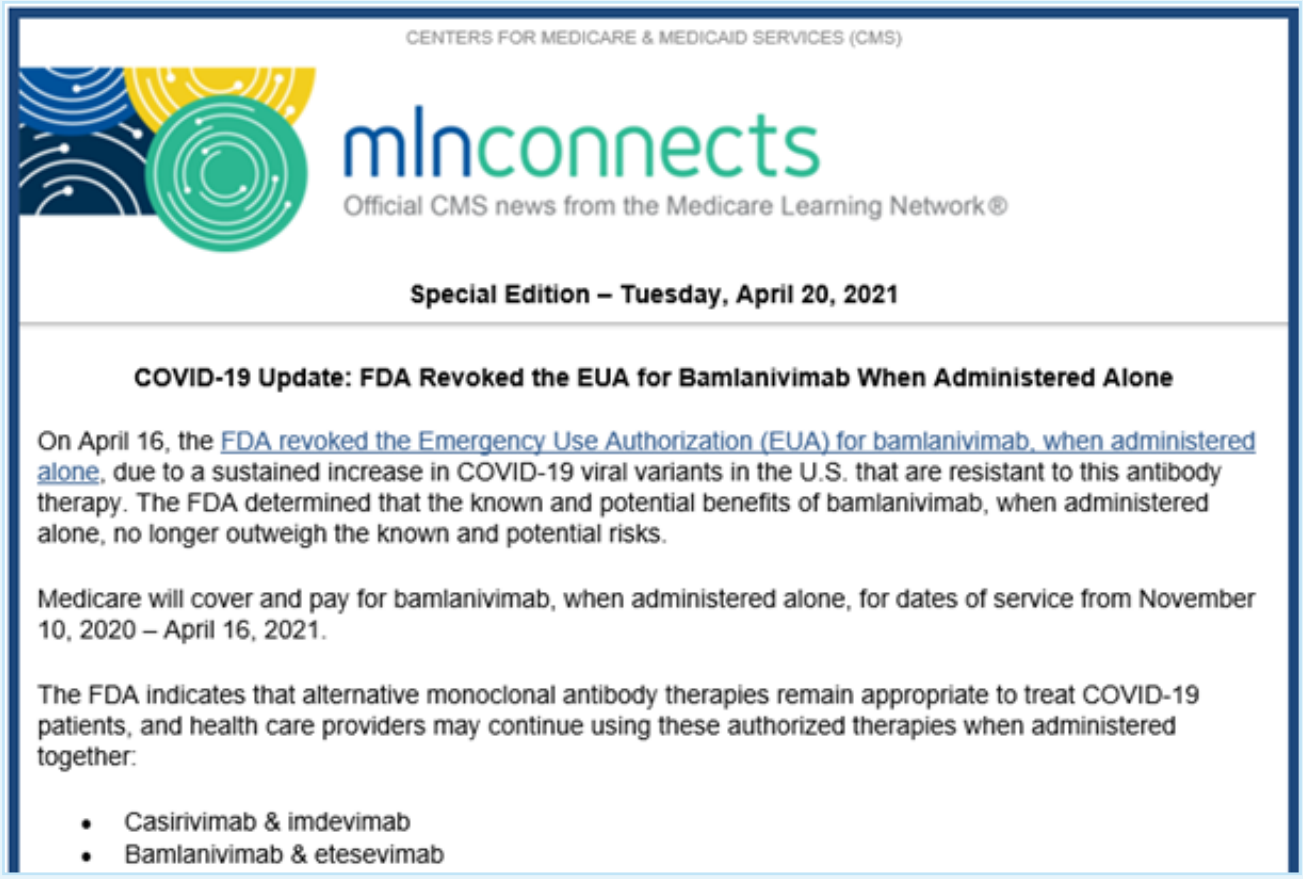
FDA REVOKES EUA FOR "SOLO" BAMLANIVIMAB

On April 16, 2021, the FDA announced that it has revokes the Emergency Use Authorization (EUA) for "solo"Bamlanivimab, the first EUA issued for monoclonal antibody treatment of a COVID-19 positive patient on an outpatient infusion basis.Consequently, Bamlanivimab may no longer be administered alone, although a new EUA permits its use only when used in combination with etesivimab.

https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-revokes-emergency-use-authorization-monoclonal-antibody-bamlanivimab

CMS issued the following MLN announcement via email to its subscribers on April 20, 2021:



CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

mlnconnects

Official CMS news from the Medicare Learning Network®

Special Edition – Tuesday, April 20, 2021

COVID-19 Update: FDA Revoked the EUA for Bamlanivimab When Administered Alone

On April 16, the FDA revoked the Emergency Use Authorization (EUA) for bamlanivimab, when administered alone, due to a sustained increase in COVID-19 viral variants in the U.S. that are resistant to this antibody therapy. The FDA determined that the known and potential benefits of bamlanivimab, when administered alone, no longer outweigh the known and potential risks.

Medicare will cover and pay for bamlanivimab, when administered alone, for dates of service from November 10, 2020 – April 16, 2021.

The FDA indicates that alternative monoclonal antibody therapies remain appropriate to treat COVID-19 patients, and health care providers may continue using these authorized therapies when administered together:

- Casirivimab & imdevimab
- Bamlanivimab & etesevimab

FDA REVOKES EUA FOR "SOLO" BAMLANIVIMAB

Bamlanivimab was first approved under an Emergency Use Authorization on November 9, 2020.Although the FDA revoked the EUA for solo bamlanivimab, the FDA issued an additional EUA for bamlanivimab in conjuction with etesivimab (continued next page):

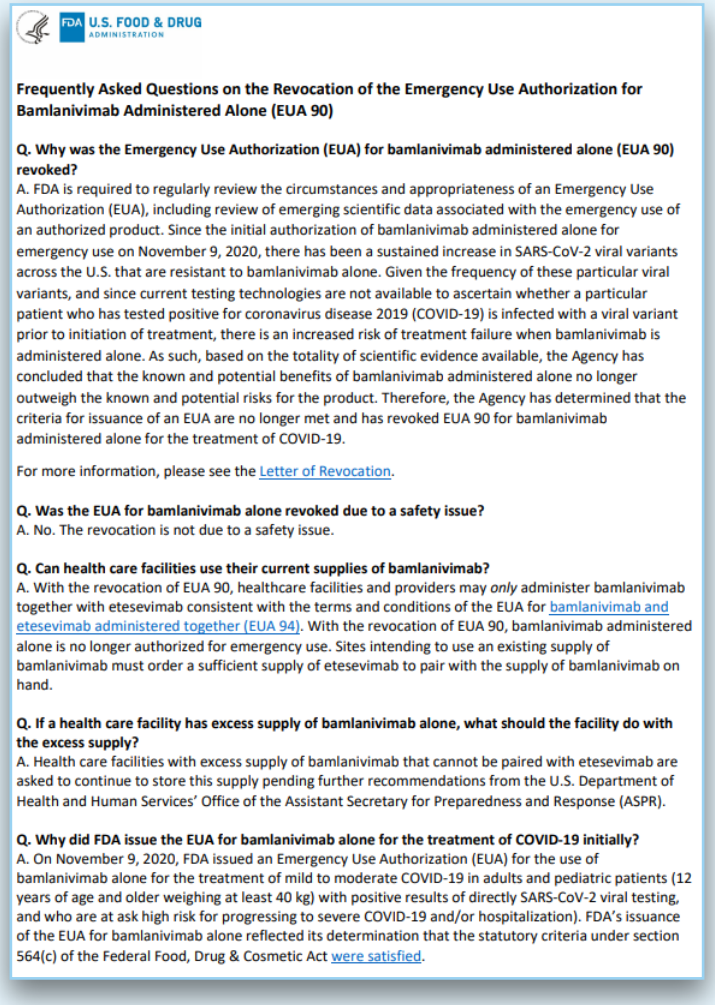
https://www.fda.gov/media/145801/download

"On February 9, 2021, the Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for emergency use of bamlanivimab and etesevimab administered together for the treatment of mild to moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progressing to severe COVID-19 and/or hospitalization. ..."

The FDA explained the revocation of "solo" Bamlanivimab as due in part to the new resistant variants of the COVID-19 virus:

"While the risk-benefit assessment for using bamlanivimab alone is no longer favorable due to the increased frequency of resistant variants, other monoclonal antibody therapies authorized for emergency use remain appropriate treatment choices when used in accordance with the authorized labeling and can help keep high risk patients with COVID-19 out of the hospital," said Patrizia Cavazzoni, M.D., director of the FDA's Center for Drug Evaluation and Research.

The FDA has posted a Frequently Asked Questions document; a link and excerpts from the FAQ are provided here: https://www.fda.gov/media/147639/download



FDA U.S. FOOD & DRUG ADMINISTRATION

Frequently Asked Questions on the Revocation of the Emergency Use Authorization for Bamlanivimab Administered Alone (EUA 90)

Q. Why was the Emergency Use Authorization (EUA) for bamlanivimab administered alone (EUA 90) revoked?
A. FDA is required to regularly review the circumstances and appropriateness of an Emergency Use Authorization (EUA), including review of emerging scientific data associated with the emergency use of an authorized product. Since the initial authorization of bamlanivimab administered alone for emergency use on November 9, 2020, there has been a sustained increase in SARS-CoV-2 viral variants across the U.S. that are resistant to bamlanivimab alone. Given the frequency of these particular viral variants, and since current testing technologies are not available to ascertain whether a particular patient who has tested positive for coronavirus disease 2019 (COVID-19) is infected with a viral variant prior to initiation of treatment, there is an increased risk of treatment failure when bamlanivimab is administered alone. As such, based on the totality of scientific evidence available, the Agency has concluded that the known and potential benefits of bamlanivimab administered alone no longer outweigh the known and potential risks for the product. Therefore, the Agency has determined that the criteria for issuance of an EUA are no longer met and has revoked EUA 90 for bamlanivimab administered alone for the treatment of COVID-19.

For more information, please see the Letter of Revocation.

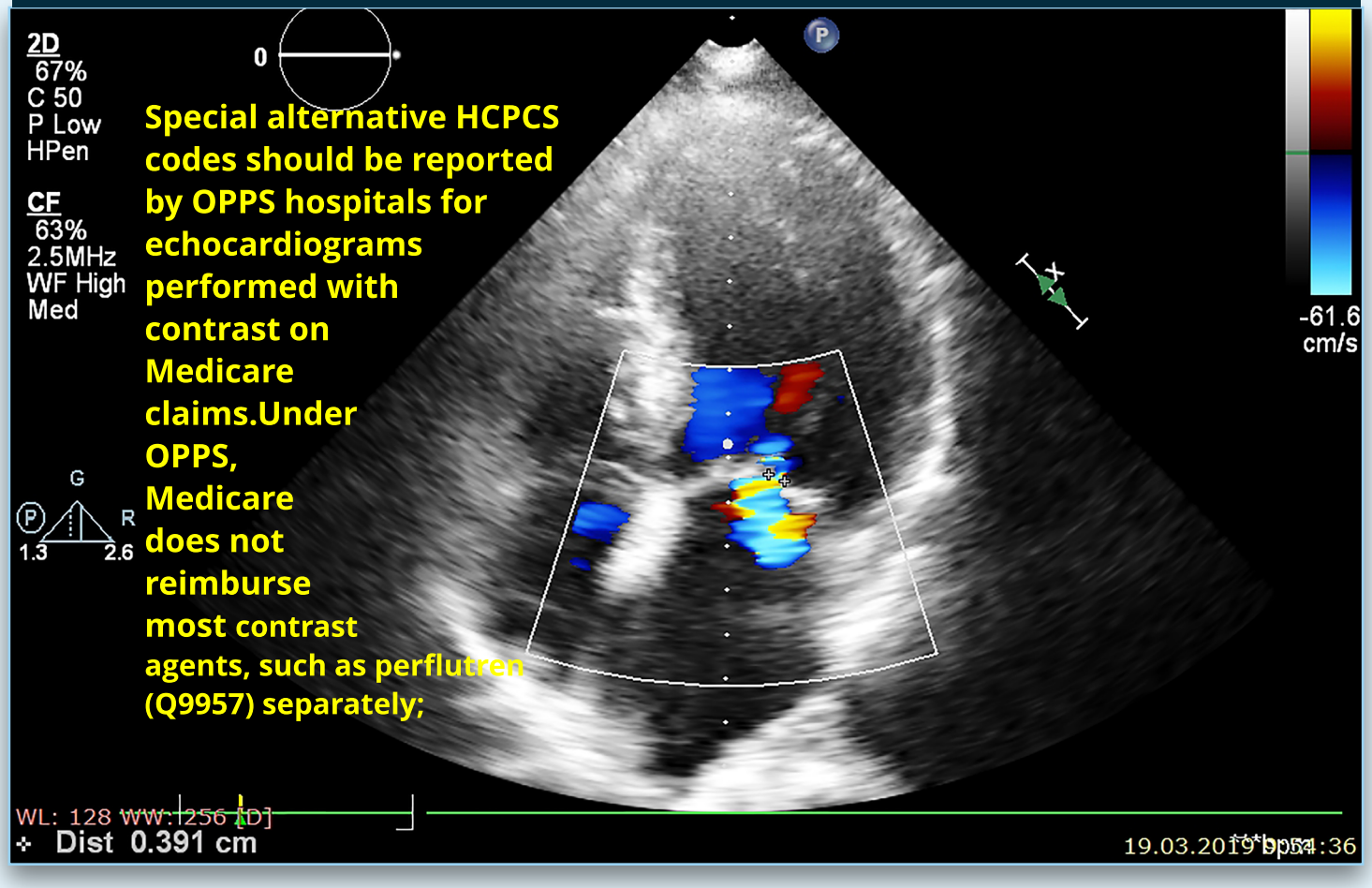
Q. Was the EUA for bamlanivimab alone revoked due to a safety issue?
A. No. The revocation is not due to a safety issue.

Q. Can health care facilities use their current supplies of bamlanivimab?
A. With the revocation of EUA 90, healthcare facilities and providers may *only* administer bamlanivimab together with etesevimab consistent with the terms and conditions of the EUA for bamlanivimab and etesevimab administered together (EUA 94). With the revocation of EUA 90, bamlanivimab administered alone is no longer authorized for emergency use. Sites intending to use an existing supply of bamlanivimab must order a sufficient supply of etesevimab to pair with the supply of bamlanivimab on hand.

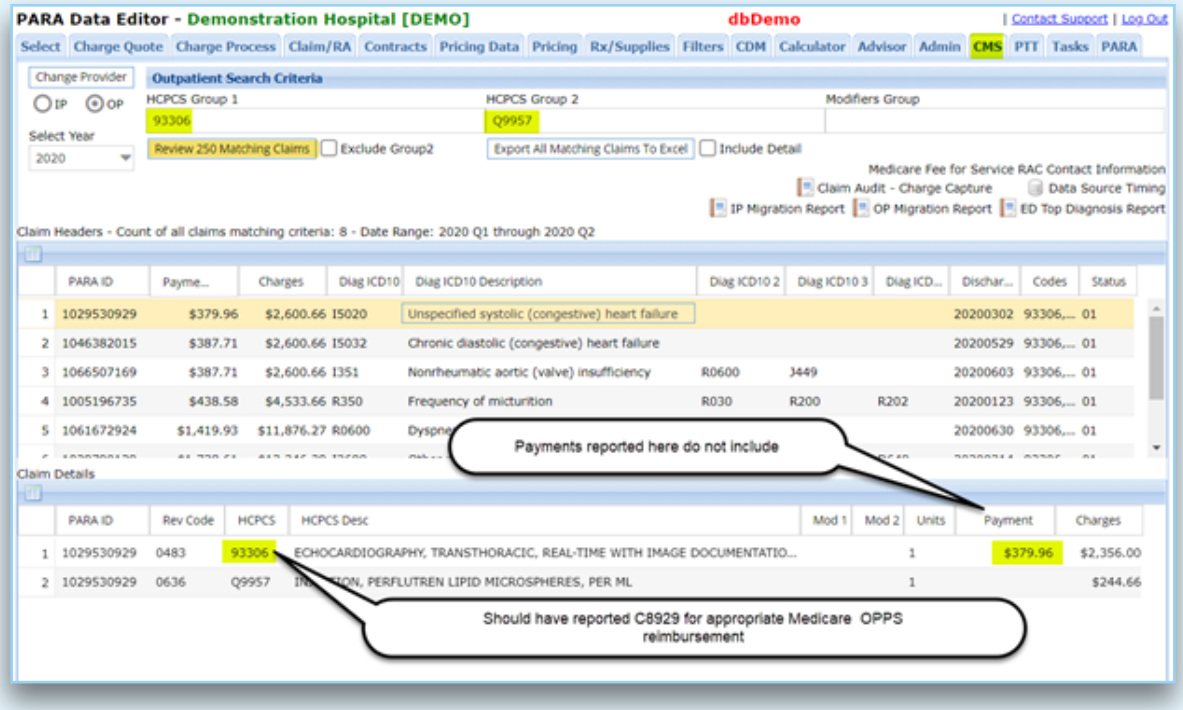
Q. If a health care facility has excess supply of bamlanivimab alone, what should the facility do with the excess supply?
A. Health care facilities with excess supply of bamlanivimab that cannot be paired with etesevimab are asked to continue to store this supply pending further recommendations from the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response (ASPR).

Q. Why did FDA issue the EUA for bamlanivimab alone for the treatment of COVID-19 initially?
A. On November 9, 2020, FDA issued an Emergency Use Authorization (EUA) for the use of bamlanivimab alone for the treatment of mild to moderate COVID-19 in adults and pediatric patients (12 years of age and older weighing at least 40 kg) with positive results of directly SARS-CoV-2 viral testing, and who are at ask high risk for progressing to severe COVID-19 and/or hospitalization). FDA's issuance of the EUA for bamlanivimab alone reflected its determination that the statutory criteria under section 564(c) of the Federal Food, Drug & Cosmetic Act were satisfied.

CODING ECHOCARDIOGRAMS WITH CONTRAST FOR MEDICARE



however, in order to recognize the cost of the contrast in its APC reimbursement, Medicare pays a higher rate for procedures performed with contrast if the alternative C89xx code is reported.The alternate HCPCS, which contain the words "with contrast" in the descriptions, are paid at a higher-ranked APC weight, resulting in a higher rate of reimbursement. **PARA Data Editor** users can identify whether the facility missed Medicare reimbursement by reporting an echocardiogram with contrast in a prior claim to Medicare on the CMS tab.Enter the echocardiogram code, such as 93306, along with the most typical contrast code used with echocardiograms, Q9957 (perflutren.)



CODING ECHOCARDIOGRAMS WITH CONTRAST FOR MEDICARE

Although most contrast agents are assigned OPPS status N (not separately paid, payment packaged to another payable line on the same claim), contrast agents should be separately reported, even when reporting the alternative HCPCS for the procedure with contrast. The table provided on the following page below indicates the most common echocardiogram CPT® codes along with the corresponding Medicare HCPCS code for reporting the same procedure when contrast is used. The higher reimbursement rate is paid on the echocardiogram procedure; contrast itself is not separately paid under OPPS.

CPT® and corresponding Alternate HCPCS "with Contrast"	OPPS Status	APC	2021 OPPS Allowed
93303 - Transthoracic echocardiography for congenital cardiac anomalies; complete	S	5524	482.29
C8921 - Transthoracic echocardiography **with contrast**, or without contrast followed by **with contrast**, for congenital cardiac anomalies; complete	S	5573	715.18
93304 - Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	S	5524	482.29
C8922 - Transthoracic echocardiography **with contrast**, or without contrast followed by **with contrast**, for congenital cardiac anomalies; follow-up or limited study	S	5573	715.18
93306 - Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography	S	5524	482.29
C8929 - Transthoracic echocardiography **with contrast**, or without contrast followed by **with contrast**, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography	S	5573	715.18
93308 - Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, follow-up or limited study	S	5523	230.13
C8924 - Transthoracic echocardiography **with contrast**, or without contrast followed by **with contrast**, real-time with image documentation (2d), includes m-mode recording, when performed, follow-up or limited study	S	5572	368.12
93312 - Echocardiography, transesophageal, real-time with image documentation (2d) (with or without m-mode recording); including probe placement, image acquisition, interpretation and report	S	5524	482.29
C8925 - Transesophageal echocardiography (tee) **with contrast**, or without contrast followed by **with contrast**, real time with image documentation (2d) (with or without m-mode recording); including probe placement, image acquisition, interpretation and report	S	5573	715.18
93315 - Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	S	5524	482.29
C8926 - Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	S	5573	715.18

CODING ECHOCARDIOGRAMS WITH CONTRAST FOR MEDICARE

Alternate "With Contrast" HCPCS -- Continued

CPT® and corresponding Alternate HCPCS "with Contrast"	OPPS Status	APC	2021 OPPS Allowed
93318 - Echocardiography, transesophageal (tee) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	S	5524	482.29
C8927 - Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	S	5573	715.18
93350 - Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	S	5524	482.29
C8928 - Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	S	5573	715.18
93351 - Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional	S	5524	482.29
C8930 - Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision	S	5573	715.18

Echocardiogram "Bubble" Studies,which use an injection of tiny bubbles from agitated normal saline to facilitates the echocardiogram imaging, should not be coded using the "with contrast" HCPCS, nor with an unlisted procedure code such as 93799.

Neither AMA nor CMS has offered coding an alternative code to report bubble studies. The absence of a CPT® code for this particular service indicates the bubble study is "integral to" the echocardiogram charge. No additional or separate charge is appropriate.

RHC/FQHC BILLING FOR GENERAL CARE MANAGEMENT SERVICES

This paper summarizes "General Care Management" programs which Rural Health Clinics and Federally Qualified Health Clinics may provide.

Care management costs are separately reimbursed on a fee schedule. The costs related to care management are reported in the non-reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate.

These programs are described in Chapter 13 of the Medicare Benefit Policy Manual; the Manual may be accessed at the link below:

Medicare Benefit Policy Manual
Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Servic

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf#

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RHC/FQHC BILLING FOR GENERAL CARE MANAGEMENT SERVICES

Care Mngt Service	Effective Date	CPT©/ HCPCS	Frequency, Duration, complexity	Reimbursement
CCM	1/1/2018	G0511	20 minutes or more within a calendar month	Separately payable 2021 - $68.80 Subsequent - Annual average of national non-facility PFS rate for 99484, 99487, 99490, 99491,G2064, G2065
General BHI	1/1/2018	G0511	20 minutes or more within a calendar month	Separately payable 2021 - $68.80 Annual average of national non-facility PFS rate for 99484, 99487, 99490, 99491,G2064, G2065
PCM	1/1/2021	G0511	30 minutes or more within a calendar month	Separately payable 2021 - $68.80 Annual average of national non-facility PFS rate for 99484, 99487, 99490, 99491,G2064, G2065
TCM	1/1/2013	99495	F2F visit w/in 14-days of Inpt discharge, moderate complexity	2021 – 99495 @ $229.56 2021—99496 @ $310.72 Payable alone as a visit under the fee schedule, or with another payable service (only one code will be reimbursed if billed same DOS.)
		99496	F2F Visit w/in 7-days of Inpt discharge, high complexity	
Psychiatric CoCM	1/1/2018	G0512	70 minutes (initial)	Separately payable 2021 - $170.62
			60 minutes (subsequent) or more within a calendar month	Annual average of national non-facility PFS rate for 99492 (70 minutes or more of initial psychiatric CoCM services) and 99493 (60 minutes or more of subsequent psychiatric CoCM services)

RHC/FQHC BILLING FOR GENERAL CARE MANAGEMENT SERVICES

Common Features of CCM, BHI, and PCM– services rendered under these three programs are reported on RHC/FQHC claims with the same HCPCS (G0511), and paid by Medicare using the same payment rate.

> **G0511 -** Rural Health Clinic or Federally Qualified Health Center (RHC OR FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month.

No Double-Dipping: RHCs and FQHCs may not bill for General Care Management and TCM services, or another program that provides additional payment for care management services (outside of the RHC AIR or FQHC PPS payment), for the same beneficiary during the same time period.HCPCS G0511, which reports services under CCM, BHI, or PCM services, can be billed only once per month per beneficiary when all requirements are met and at least the following time-based services have been furnished:

- 20 minutes of CCM services, or
- at least 30 minutes of PCM services, or
- at least 20 minutes of general BHI services

Initiating Visit -- A separately billable initiating visit with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) is required before care management services can be furnished.

- The visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services
- Care management services do not need to have been discussed during the initiating visit, and the same initiating visit can be used for CCM and BHI services as long as it occurs with an RHC or FQHC primary care practitioner within one year of commencement of care management services.
- Beneficiary consent to receive care management services must be obtained either by or under the direct supervision of the RHC or FQHC primary care practitioner, may be written or verbal and must be documented in the patient's medical record before CCM or BHI services are furnished.
- The medical record should document that the beneficiary has been informed about the availability of care management services, has given permission to consult with relevant specialists as needed, and has been informed of all of the following:
    - There may be cost-sharing (e.g. deductible and coinsurance in RHCs, and coinsurance in FQHCs) for both in-person and non-face-to-face services that are provided;
    - Only one practitioner/facility can furnish and be paid for these services during a calendar month; and
    - They can stop care management services at any time, effective at the end of the calendar month.

Following the initiating visit and patient consent, the General Care Management Services programs (CCM, BHI, or PCM)do not require face-to-face visits. Each program requires documentation of certain non-face-to-face services performed by the RHC clinician or auxiliary staff.

RHC/FQHC BILLING FOR GENERAL CARE MANAGEMENT SERVICES

Payment Rate: G0511 is paid at the average of the national non-facility Medicare Physician Fee Schedule payment rate for CPT® codes 99490, 99487, 99484, 99491, and HCPCS codes G2064 and G2065. General care management HCPCS code G0511 is separately payable on an RHC or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0511 is updated annually based on the PFS amounts for these codes.

Effective 1/1/2021, the payment rate for G0511 is the average of the following CPT®/HCPCS:

HCPCS/CPT®	2021 National, Non-Facility MPFS Rate
99484 - Care management services for behavioral health conditions…20 mins. clinical staff time per month…	51.65
99487 - Complex chronic care management services … first 20 minutes of clinical staff time per month	102.67
99490 - Chronic care management services …first 20 Mins. clinical staff time…	45.09
99491 - Chronic care management services…30 mins. Physician/ QHP time per month…	89.02
G2064 - Comprehensive care management services …30 mins. physician/QHP time per month…	82.17
G2065 - Comprehensive care management for a single high-risk disease…20 mins. clinical staff time per month…	42.22
2021 Average -- G0511 RHC/FQHC reimbursement rate	**$68.80**

Coinsurance for care management services is 20 percent of the lesser of submitted charges or the payment rate for G0511.

Chronic Care Management (CCM) – Effective January 1, 2016, RHCs and FQHCs are paid for CCM services when a minimum of 20 minutes of qualifying CCM services during a calendar month is furnished. CCM services may be furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

RHC/FQHC BILLING FOR GENERAL CARE MANAGEMENT SERVICES

CCM service requirements include:

- **Structured recording of patient health information using Certified EHR Technology** including demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care;

- **24/7 access to physicians or other qualified health care professionals or clinical staff** including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;

- **Comprehensive care management** including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications;

- **Comprehensive care plan** including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;

- **Care plan information made available electronically** (including fax) in a timely manner within and outside the RHC or FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver;

- **Management of care transitions** between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;

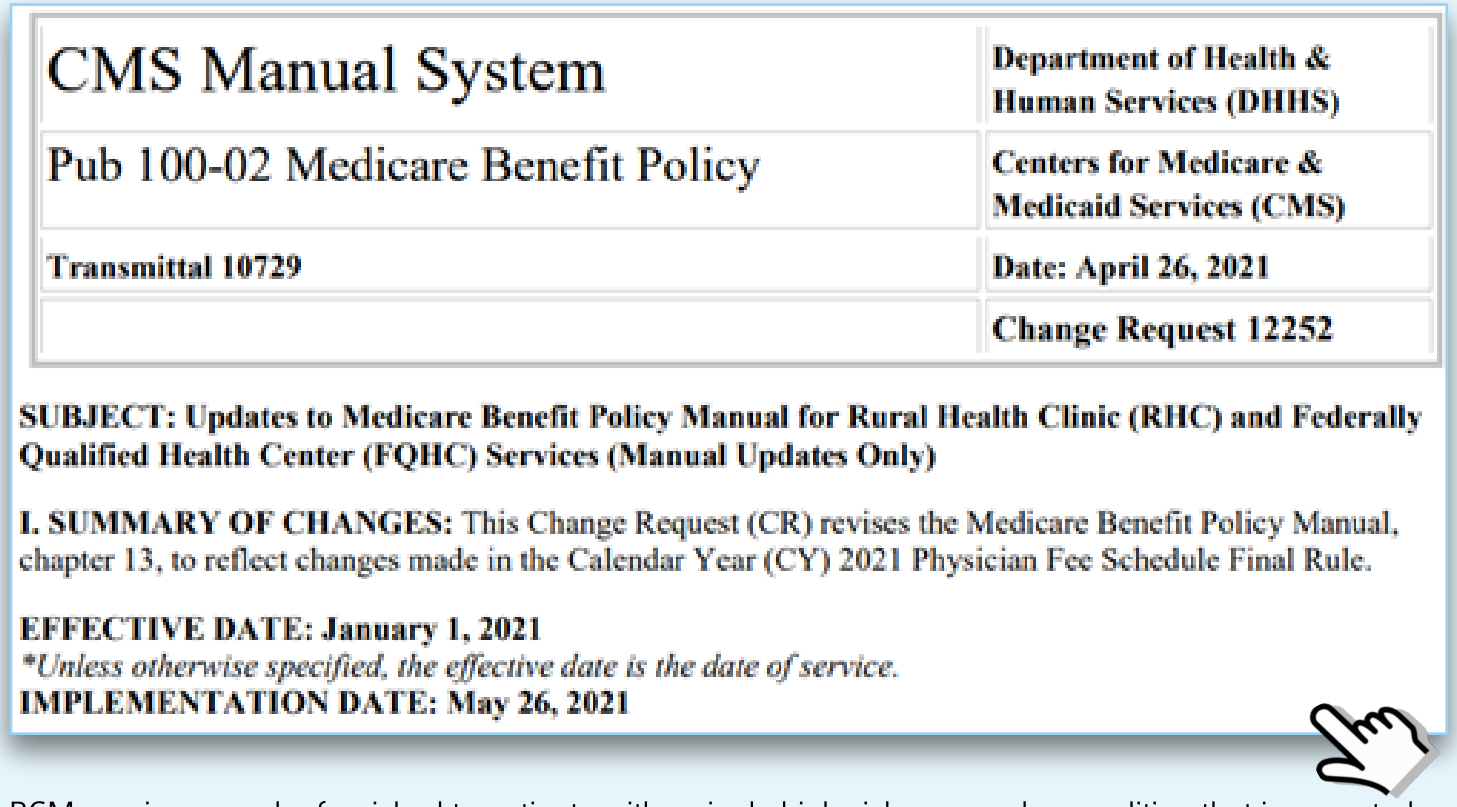
- **Coordination with home- and community-based clinical service providers,** and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record; and

- **Enhanced opportunities for the patient and any caregiver to communicate** with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

RHC/FQHC BILLING FOR GENERAL CARE MANAGEMENT SERVICES

Principal Care Management (PCM) -- Effective January 1, 2021, RHCs and FQHCs are paid for PCM services when a minimum of 30 minutes of qualifying PCM services are furnished during a calendar month.The CMS transmittal which updates the Benefit Policy Manual is found at:

https://www.cms.gov/files/document/r10729bp.pdf



CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10729	Date: April 26, 2021
	Change Request 12252

SUBJECT: Updates to Medicare Benefit Policy Manual for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services (Manual Updates Only)

I. SUMMARY OF CHANGES: This Change Request (CR) revises the Medicare Benefit Policy Manual, chapter 13, to reflect changes made in the Calendar Year (CY) 2021 Physician Fee Schedule Final Rule.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 26, 2021

PCM services may be furnished to patients with a single high-risk or complex condition that is expected to last at least 3 months and may have led to a recent hospitalization, and/or placed the patient at significant risk of death.

PCM service requirements include:

- A single complex chronic condition lasting at least 3 months, which is the focus of the care plan;
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization;
- The condition requires development or revision of disease-specific care plan;
- The condition requires frequent adjustments in the medication regiment; and
- The condition is unusually complex due to comorbidities.

RHC/FQHC BILLING FOR GENERAL CARE MANAGEMENT SERVICES

Behavioral Health Integration (BHI)

BHI is a team-based, collaborative approach to care that focuses on integrative treatment of patients with primary care and mental or behavioral health conditions. Effective January 1, 2018, RHCs and FQHCs are paid for general BHI services when a minimum of 20 minutes of qualifying general BHI services during a calendar month is furnished to patients with one or more new or pre-existing behavioral health or psychiatric conditions being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC primary care practitioner, warrants BHI services.

General BHI service requirements include:

- An initial assessment and ongoing monitoring using validated clinical rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team

Transitional Care Management (TCM)

TCM services must be furnished within 30 days of the date of the patient's discharge from a hospital (including outpatient observation or partial hospitalization), SNF, or community mental health center.

Communication (direct contact, telephone, or electronic) with the patient or caregiver must commence within 2 business days of discharge, and a face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (CPT® code 99495), or within 7 days of discharge for high complexity decision making (CPT® code 99496). A Transitional Care Management (TCM) service can also be an RHC or FQHC visit.

The TCM visit is billed on the day that the TCM visit takes place, and only one TCM visit may be paid per beneficiary for services furnished during that 30 day post-discharge period.

TCM services are billed by adding CPT® code 99495 or CPT® code 99496 to an RHC or FQHC claim, either alone or with other payable services. If it is the only medical service provided on that day with an RHC or FQHC practitioner it is paid as a stand-alone billable visit. If it is furnished on the same day as another visit, only one visit is paid.In other words, a Transitional Care Management (TCM) service can also be a RHC visit.

Psychiatric Collaborative Care Model (CoCM)

Psychiatric CoCM is a specific model of care provided by a primary care team consisting of a primary care provider and a health care manager who work in collaboration with a psychiatric consultant to integrate primary health care services with care management support for patients receiving behavioral health treatment. It includes regular psychiatric inter-specialty consultation with the primary care team, particularly regarding patients whose conditions are not improving.

RHC/FQHC BILLING FOR GENERAL CARE MANAGEMENT SERVICES

The primary care team regularly reviews the beneficiary's treatment plan and status with the psychiatric consultant and maintains or adjusts treatment, including referral to behavioral health specialty care, as needed. Patients with mental health, behavioral health, or psychiatric conditions, including substance use disorders, who are being treated by an RHC or FQHC practitioner may be eligible for psychiatric CoCM services, as determined by the RHC or FQHC primary care practitioner.

A separately billable **initiating visit** with an RHC or FQHC primary care practitioner (physician, NP, PA, or CNM) is required before psychiatric CoCM services can be furnished. This visit can be an E/M, AWV, or IPPE visit, and must occur no more than one-year prior to commencing care management services. Psychiatric CoCM services do not need to have been discussed during the initiating visit, and the same initiating visit can be used for psychiatric CoCM as for CCM and BHI services, as long as it occurs with an RHC or FQHC primary care practitioner within one year of commencement of psychiatric CoCM services.

Beneficiary consent to receive care management services must be obtained either by or under the direct supervision of the RHC or FQHC primary care practitioner, may be written or verbal and must be documented in the patient's medical record before psychiatric CoCM services are furnished. The medical record should document that the beneficiary has been informed about the availability of care management services, has given permission to consult with relevant specialists as needed, and has been informed of all of the following:

- There may be cost-sharing (e.g. deductible and coinsurance in RHCs, and coinsurance in FQHCs) for both in-person and non-face-to-face services that are provided;
- Only one practitioner/facility can furnish and be paid for these services during a calendar month; and
- They can stop care management services at any time, effective at the end of the calendar month

Beneficiary consent remains in effect unless the beneficiary opts out of receiving care management services. If the beneficiary chooses to resume care management services after opting out, beneficiary consent is required before care management services can resume. If the beneficiary has not opted out of care management services but there has been a period where no care management services were furnished, a new beneficiary consent is not required.

CoCM RHC or FQHC Practitioner Requirements -- The RHC or FQHC practitioner is a primary care physician, NP, PA, or CNM who:

- Directs the behavioral health care manager and any other clinical staff;
- Oversees the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed; and
- Remains involved through ongoing oversight, management, collaboration and reassessment. Behavioral Health Care Manager Requirements

RHC/FQHC BILLING FOR GENERAL CARE MANAGEMENT SERVICES

CoCM Behavioral Health Care Manager is a designated individual with formal education or specialized training in behavioral health, including social work, nursing, or psychology, and has a minimum of a bachelor's degree in a behavioral health field (such as in clinical social work or psychology), or is a clinician with behavioral health training, including RNs and LPNs. The behavioral health care manager furnishes both face-to-face and non-face-to-face services under the general supervision of the RHC or FQHC practitioner and may be employed by or working under contract to the RHC or FQHC.

The behavioral health care manager:

- Provides assessment and care management services, including the administration of validated rating scales;
- Provides behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Provides brief psychosocial interventions;
- Maintains ongoing collaboration with the RHC or FQHC practitioner;
- Maintains a registry that tracks patient follow-up and progress;
- Acts in consultation with the psychiatric consultant;
- Is available to provide services face-to-face with the beneficiary; and
- Has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team

CoCM Psychiatric Consultant Requirements -- The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of medications. The psychiatric consultant is not required to be on site or to have direct contact with the patient and does not prescribe medications or furnish treatment to the beneficiary directly. The psychiatric consultant:

- Participates in regular reviews of the clinical status of patients receiving psychiatric CoCM services;
- Advises the RHC or FQHC practitioner regarding diagnosis and options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments; and
- Facilitates referral for direct provision of psychiatric care when clinically indicated.

RHC/FQHC BILLING FOR GENERAL CARE MANAGEMENT SERVICES

Payment for Psychiatric CoCM Psychiatric CoCM services furnished on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for CPT® codes 99492 (70 minutes or more of initial psychiatric CoCM services) and CPT® code 99493 (60 minutes or more of subsequent psychiatric CoCM services) when psychiatric CoCM HCPCS code, G0512, is on an RHC or FQHC claim, either alone or with other payable services. This rate is updated annually based on the PFS amounts for these codes.

At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months, of psychiatric CoCM services must have been furnished in order to bill for this service.

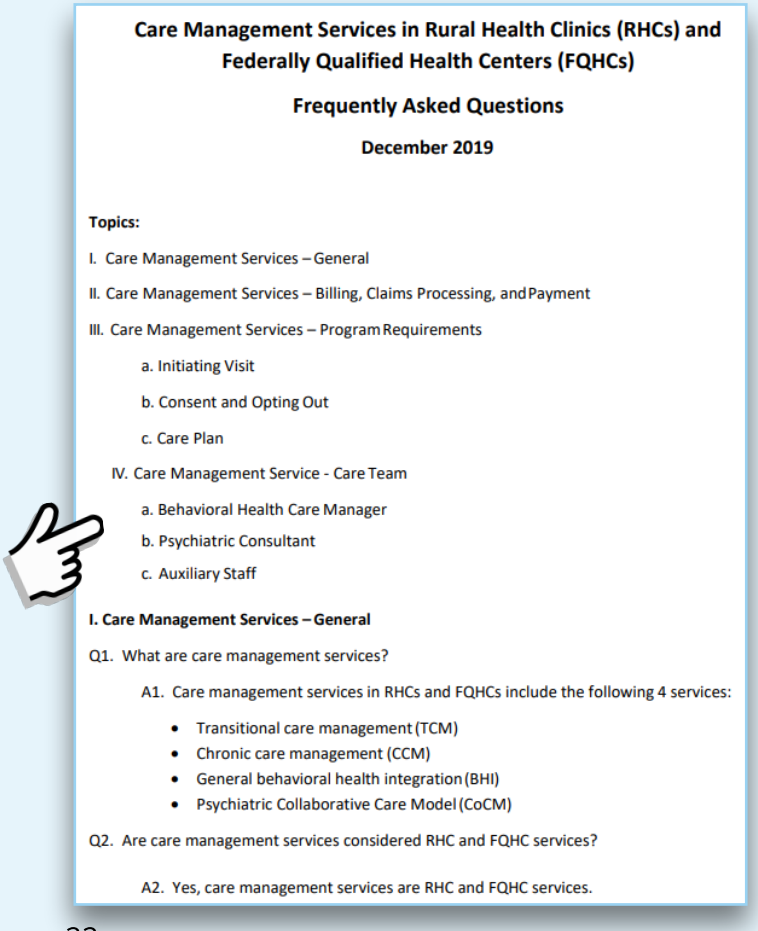
Coinsurance for psychiatric CoCM services is 20 percent of the lesser of submitted charges or the payment rate for G0512.

Psychiatric CoCM costs are reported in the non-reimbursable section of the cost report and are not used in determining the RHC AIR or the FQHC PPS rate.

G0512 can be billed once per month per beneficiary when all requirements have been met. Only services furnished by an RHC or FQHC practitioner or auxiliary personnel that are within the scope of service elements can be counted toward the minimum 60 minutes that is required to bill for psychiatric CoCM services and does not include administrative activities such as transcription or translation services.

Additional information is available at the following link, although this FAQ has not yet been updated to add Principal Care Management, which became effective on 1/1/2021:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf



Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Frequently Asked Questions

December 2019

Topics:

I. Care Management Services – General

II. Care Management Services – Billing, Claims Processing, and Payment

III. Care Management Services – Program Requirements

a. Initiating Visit

b. Consent and Opting Out

c. Care Plan

IV. Care Management Service - Care Team

a. Behavioral Health Care Manager

b. Psychiatric Consultant

c. Auxiliary Staff

I. Care Management Services – General

Q1. What are care management services?

A1. Care management services in RHCs and FQHCs include the following 4 services:

- Transitional care management (TCM)
- Chronic care management (CCM)
- General behavioral health integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)

Q2. Are care management services considered RHC and FQHC services?

A2. Yes, care management services are RHC and FQHC services.

PHE STATUS RENEWED ANOTHER 90 DAYS

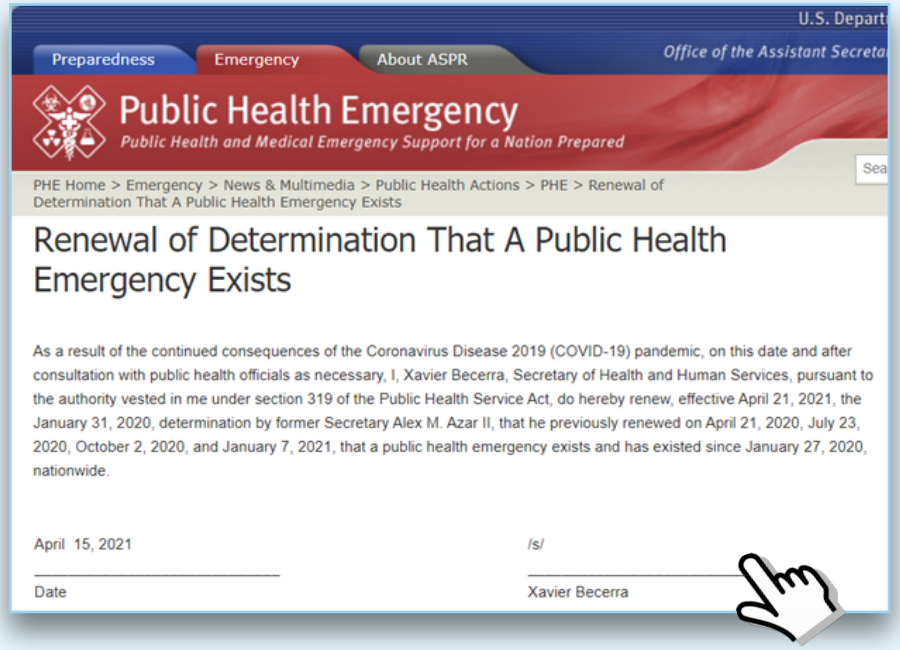
The newly confirmed Secretary for Health and Human Services, Xavier Becerra, renewed the COVID-19 Public Health Emergency (PHE) for up to an additional 90-day period as of April 21, 2021.

https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVID-15April2021.aspx

According to the HHS Frequently Asked Question website, the PHE may be terminated either at the end of the 90-day extension, or whenever the Secretary declares the PHE no longer exists:

https://www.phe.gov/Preparedness/legal/Pages/phe-qa.aspx#faq7

This latest extension will expire on July 20, 2021, unless another extension is declared by the Secretary, or unless the Secretary declares the PHE no longer exists earlier than that date.



7. **How long does a PHE declaration last?**

A PHE declaration lasts until the Secretary declares that the PHE no longer exists or upon the expiration of the 90-day period beginning on the date the Secretary declared a PHE exists, whichever occurs first. The Secretary may extend the PHE declaration for subsequent 90-day periods for as long as the PHE continues to exist, and may terminate the declaration whenever he determines that the PHE has ceased to exist.

PARA HealthCare Analytics | HEALTHCARE FINANCIAL RESOURCES

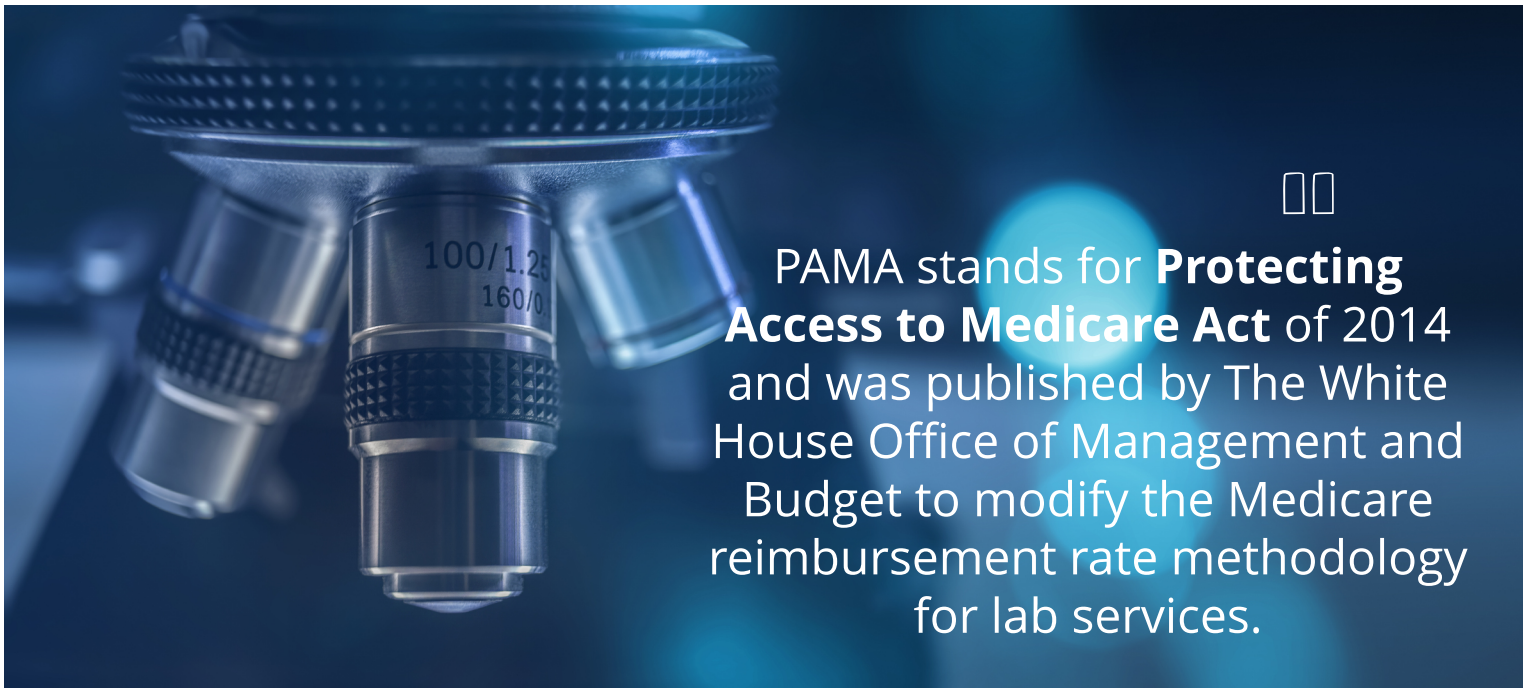
A COMPLIANCE GUIDE FOR LABORATORIES & HOSPITALS

Protecting Access To Medicare Act

Laboratory Private Payer Rate Reporting Requirements

Pricing | Coding | Reimbursement | Compliance

BACKGROUND



Introduction

CMS created the CLFS to guarantee the new fee schedule continues to ensure adequate access to lab services for Medicare beneficiaries. But, the pre-PAMA Medicare Clinical Lab Fee Schedule (CLFS) payments were based on 1984 cost data and sometimes updated for inflation.

A limited reconsideration process was in place for new tests.The hope for the new CLFS was that by performing a market-based pricing exercise, pricing could be brought up to date and in-line with current practices.

THE DETAILS

PAMA reporting requirements apply to any "applicable laboratory." An applicable laboratory is a laboratory that receives a majority of its Medicare revenue under the CLFS, the Physician Fee Schedule ("PFS"), or the new section 1834A of the Social Security Act, as added by PAMA.

What's An Applicable Lab?

Hospital Labs Serving:

- Inpatients
- Outpatients
- Non-Patients ("Outreach")

Physician Office Labs Performing:

- Point of Care/Traditional Tests
- Provider-Performed Microscopy
- Pathologists' Practices

Independent Labs Performing:

- Standard Tests
- Drug Abuse Testing
- Molecular Diagnostics

- A laboratory, as defined in CLIA, that bills Medicare Part B under its own NPI
- And receives the majority of its Medicare revenue from the PFS or CLFS
- And receives more than $12,500 Medicare revenue from the CLFS in a year
- The $12,500 threshold does not apply to a single laboratory that furnishes an ADLT (but does apply to any CDLTs that the laboratory performs)

THE COST OF NON-COMPLIANCE

CMPs

WHAT LEADERS NEED TO KNOW

"We are revising the certification and CMP (Civil Monetary Penalties) policies in the final rule to require that the accuracy of the data be certified by the President, CEO, or CFO of the reporting entity, or an individual who has been designated to sign for, and who reports directly to such an officer.

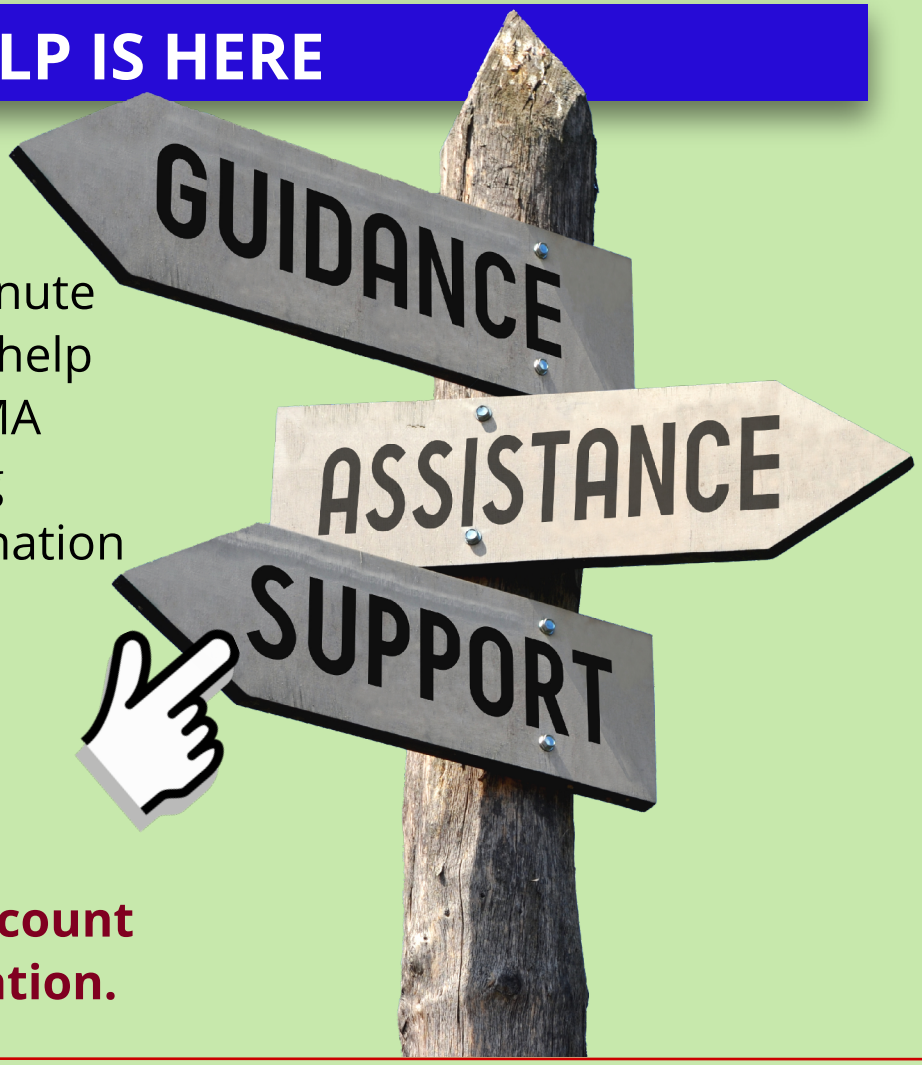
Similarly, the reporting entity will be subject to CMPs for the failure to report or the misrepresentation or omission in reporting applicable information."

Current CMP Rate: $10,017 Per Day.

REQUIREMENTS CAN BE CONFUSING

LET PARA POINT THE WAY THROUGH THE LAB PAYMENT REPORTING MAZE

HELP IS HERE



PARA has developed a 30-minute online presentation that can help keep you compliant with PAMA laboratory rate and reporting requirements. It's vital information for all clinical laboratories.

Click the signs to watch.

Then contact your PARA Account Executive for more information.

Our amazing guides.

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JOHNSON & JOHNSON JANSSEN COVID-19 VACCINES MAY CONTINUE

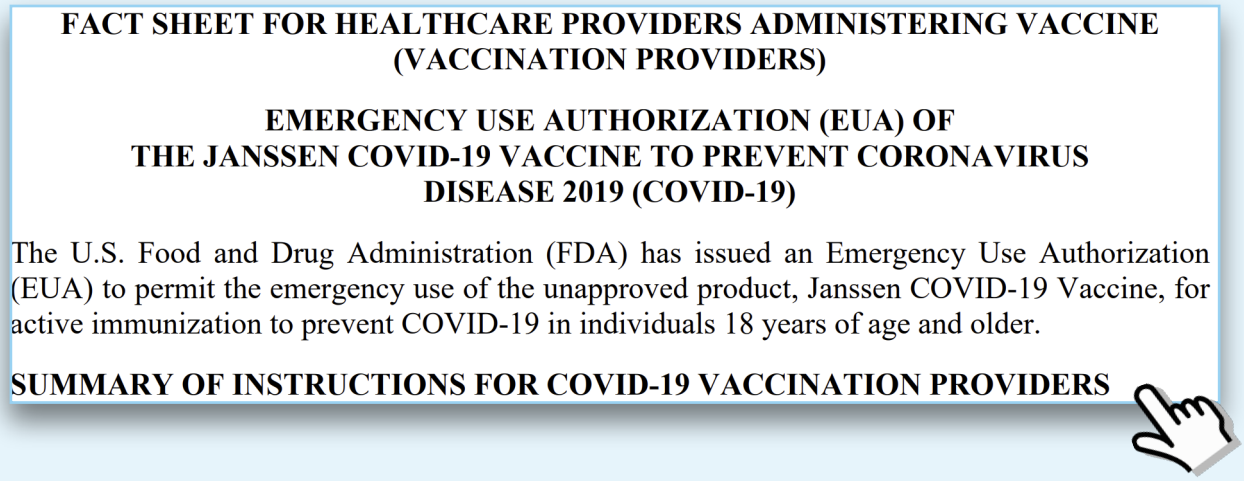
After a short pause on from April 13, 2021 to April 23, 2021 the FDA and CDC recommends resuming administration of the Janssen COVID-19 vaccine for individuals 18 years old and older.

As with other vaccines, the most common side effects are pain at the injection site, muscle aches, nausea, and headaches.Those side effects generally last one to two days.

The Janssen COVID-19 vaccine was paused after several immunized individuals developed thrombosis-thrombocytopenia syndrome (TTS).While both the FDA and CDC will continue to investigate risk with all COVID-19 vaccines, they recommend all practitioners administering the Janssen vaccine review the Janssen COVID-19 Vaccine Fact Sheet for Healthcare Providers Administering Vaccine (Vaccine Providers) and the Fact Sheet for Recipients which are revised with the risk about the syndrome.

Fact Sheet for Healthcare Providers Administering Vaccine (Vaccine Providers)

https://www.fda.gov/media/146304/download



FACT SHEET FOR HEALTHCARE PROVIDERS ADMINISTERING VACCINE (VACCINATION PROVIDERS)

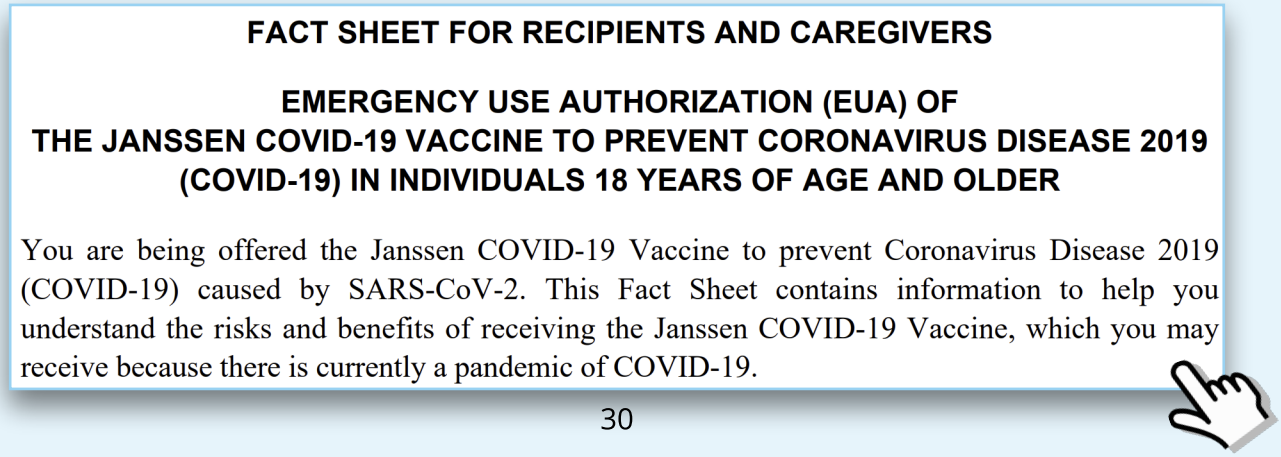
EMERGENCY USE AUTHORIZATION (EUA) OF THE JANSSEN COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19)

The U.S. Food and Drug Administration (FDA) has issued an Emergency Use Authorization (EUA) to permit the emergency use of the unapproved product, Janssen COVID-19 Vaccine, for active immunization to prevent COVID-19 in individuals 18 years of age and older.

SUMMARY OF INSTRUCTIONS FOR COVID-19 VACCINATION PROVIDERS

Fact Sheet for Recipients and Caregivers

https://www.fda.gov/media/146305/download



FACT SHEET FOR RECIPIENTS AND CAREGIVERS

EMERGENCY USE AUTHORIZATION (EUA) OF THE JANSSEN COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER

You are being offered the Janssen COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of receiving the Janssen COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

FOUR STRATEGIC AREAS FOR MITIGATING REVENUE LOSS

ADAPT QUICKLY TO LOST REVENUE AS PANDEMIC ROLLS ON

With the end of the pandemic still over the horizon, hospitals and health systems must continue to adapt to utilization changes and other financial challenges set in motion by COVID-19.

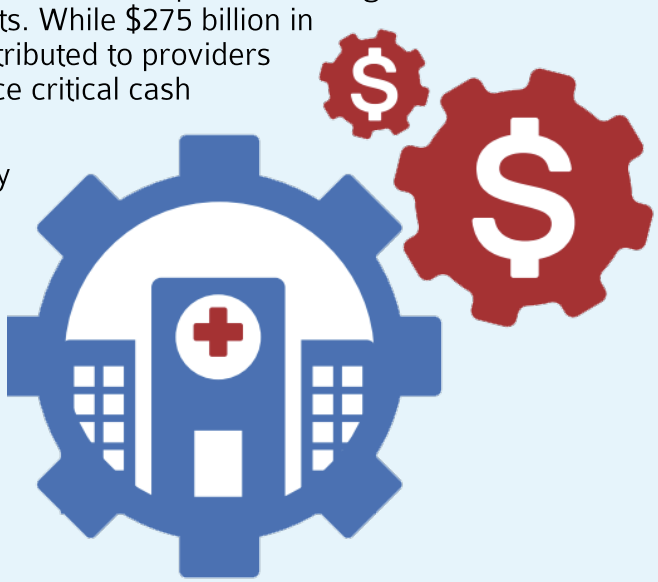
For many, that means fundamentally reassessing—and, in some cases, reengineering—their core operations to help ensure sustainability in the post-pandemic world. New approaches to administrative staffing, revenue cycle management, reimbursement, and pricing strategies are required to ensure staff availability, control labor costs, replace lost revenue, and reduce revenue leakage.

Organizations also must establish the tools necessary to comply with new regulatory requirements, most notably the CMS price transparency rule, or potentially face significant financial penalties.

GREATEST HOSPITAL FINANCIAL CRISIS IN HISTORY

Although the sharp drop in utilization seen in the early months of the pandemic had begun to abate in the second half of 2020, hospitals were still projected to lose $323 billion for the year in what the American Hospital Association called the "the greatest financial crisis in our history."[1] About three dozen hospitals nationwide had entered bankruptcy by October 2020, according to AHA.[2]

For the full year, hospital operating room minutes fell by 11%, adjusted discharges dropped by 10% and ED visits were reduced by 16%.[3] Along with falling revenues, most hospitals faced higher costs associated with sustaining safe work and care environments. While $275 billion in Cares Act funding and emergency Medicare loans was distributed to providers through the year, many organizations were expected to face critical cash shortages without additional aid.[4]



In fact, hospital and health system operating margins fell by almost 20% in of 2020; without the relief funding provided by the CARES Act, the decline would have been nearly 70%.[5]

FOUR STRATEGIC AREAS FOR MITIGATING REVENUE LOSS

Whether, and to what extent, the industry can return to its pre-pandemic state remains unknown. But rather than simply waiting and hoping for the best, here are four key areas hospitals can address right now to mitigate or reverse revenue losses:

1. Staffing

Of the many operational challenges that have accompanied the pandemic, sustaining consistent patient financial services amid staffing shortages has been one of the most problematic. Between employees who are out for testing, in quarantine, fighting the virus or have taken time off to care for a sick loved one, paid time-off among back-office staff has jumped.

These workforce absences have created difficulties in sustaining operational continuity and organizational performance. As a result, hospitals have been compelled to hire temporary workers from professional staffing firms. But many of these organizations have raised their rates in response to increased demand.

Remote workforce

To address the problem, a growing number of hospitals have established and solidified remote workforce capabilities. Key considerations include ensuring that your remote platform is equipped with appropriate security parameters to safeguard protected health information.

The benefits of establishing a remote workforce include improved morale, greater scheduling flexibility and new options for repurposing or eliminating existing office space to reduce overhead.

Perhaps most importantly, remote working capabilities allow organizations to draw from a more diverse and expansive talent pool. Hospitals that previously were limited to pulling staff from their immediate geographic area can now recruit and employ individuals from virtually anywhere in the U.S. This enables organizations to reduce the possibility of staff shortages while ensuring the highest-quality hires.

Training and platform consistency

Whether the workforce is remote or onsite, keeping track of varying rules, regulations and guidelines across different regions, carriers and hospitals can be a lot to manage. Hence, ensuring uniformity of work by both in-house staff and outside vendors is essential.

That's why it is important to work with a vendor that can provide a standardized platform that enables automated, system-wide rules updates. This approach can facilitate the seamless transfer of consistent rules and knowledge in instances when employees retire, leave or are out for an extended period of time.

Accuracy and consistency are critical: If an account is worked incorrectly at the outset, collectability can be affected by 50%. Moreover, the tighter the time limits on accounts, the less collectable the account becomes with the passage of time.

Along with enabling automated, system-wide updates, platforms should incorporate ongoing training modules, work-from-home protocols, and features for monitoring employee performance and time-on-task.

Assembling a viable work-from-home platform isn't an enormous lift from an IT perspective, but continual training of new hires or temporary employees can be challenging. As a result, it may be faster and make more sense, both financially and operationally, to partner with a third-party vendor capable of quickly implementing a turnkey solution, especially if that vendor has additional tools to automate processes for reducing denials, improving cash flow and collecting outstanding AR.

2. Utilization And Payer Mix

Worries about capacity constraints during COVID-19's second surge through the fall and winter of 2020 led many hospitals to once more defer elective procedures as they had in the early months of the pandemic. Now, with COVID-19 hospitalization rates finally dropping, many patients that were unable to receive procedures in 2020 are scheduling for inpatient care.

But payer mixes are shifting: Studies estimate that between 3 million and 7 million employees and dependents lost employer-based coverage in 2020.[6] At the same time, Medicaid and CHIP enrollment increased, rising by 6.1 million people nationwide, or 8.6%, between February and September 2020.[7]

The CARES Act included a provision for reimbursing hospitals for treatment of uninsured COVID-19 patients. But the program has paid out only limited amounts and was not designed to provide the same level of coverage as traditional insurance.[8] As a result, hospitals' uncompensated care costs are expected to rise as the numbers of uninsured and uninsured seeking care due to COVID-19 and other conditions increase.

3. Ensuring Optimal Reimbursement

Given rising utilization and a deteriorating payer mix, it is critical that hospitals have access to metrics that can monitor their top payers on a regular, near-real time basis. This allows for prompt intervention and limits the financial damage if payer claims are delayed or are unpaid.

Specifically, utilizing CARC and RARC codes from EDI payer data enables organizations to assess denial issues and determine where and why payers are delaying reimbursement. The ability to compare average charges billed and contractually applied versus allowable limits is also essential. Finally, systems that can confirm the accuracy of patient demographic and payer information at the outset of care can prevent denials from occurring in the first place.

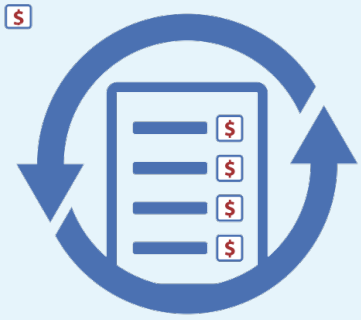
Platforms that monitor coding processes also help ensure appropriate reimbursement and limit denials. Effective January 1, 2021, the Centers for Disease Control announced the implementation of six new ICD-10-CM codes to identify conditions related to COVID-19. Making sure these codes are applied correctly and consistently will be vital in optimizing reimbursement for short-term and long-term COVID-19 patients. Similarly, the rise in telehealth care requires that hospitals and health systems have the means to ensure these services are coded properly.

Critically, denials must be expertly and expeditiously managed when they do occur. Scalable, client-specific accounts receivable resolution and recovery solutions are available to allow hospitals to systematically address problem claims across the full AR spectrum.

These systems can address issues with government and commercial payers, as well as managed care, worker's compensation, and personal injury claims. Technology can also provide rules and guidelines built directly into workflows to create a centralized location for information along with auto-notation which provides uniform message choices. Platforms using intelligent automation and powerful process engineering prioritizes AR inventory automatically while providing tailored work lists to specialized analysts, increasing efficiency in the resolution of all claims, regardless of size or age. That means hospitals are able to recover collections from insurance claims that traditionally would have been written off.

FOUR STRATEGIC AREAS FOR MITIGATING REVENUE LOSS

4. Pricing



Equally important from a revenue optimization perspective is a market-based pricing strategy built around cost, reimbursement, and peer pricing data. This approach ensures hospitals are aligned with peer group averages while simultaneously positioned to capitalize on opportunities for maximizing returns on below-price items and services.

Capable vendors can assist in this process and will revisit the pricing model on a regular basis to allow for course corrections and adjustments based on changing internal or external circumstances. For example, in the current environment, it's important to have the ability to quickly adjust pricing based on sudden changes in volume. This requires a detailed understanding of costs, including time, supplies and labor, as well as payer contracted charges and prices.

Optimized pricing is a critical first step in meeting the obligations of the Centers For Medicare And Medicaid pricing transparency rule which took effect January 1, 2021, and requires the publication of inpatient and outpatient procedure pricing online.

Those providers who work with a qualified vendor to both calculate appropriate and competitive prices and develop the tools to make that information readily available via the internet will have a significant competitive advantage over those that do not. Equally important, they will mitigate potentially severe financial risks of non-compliance.

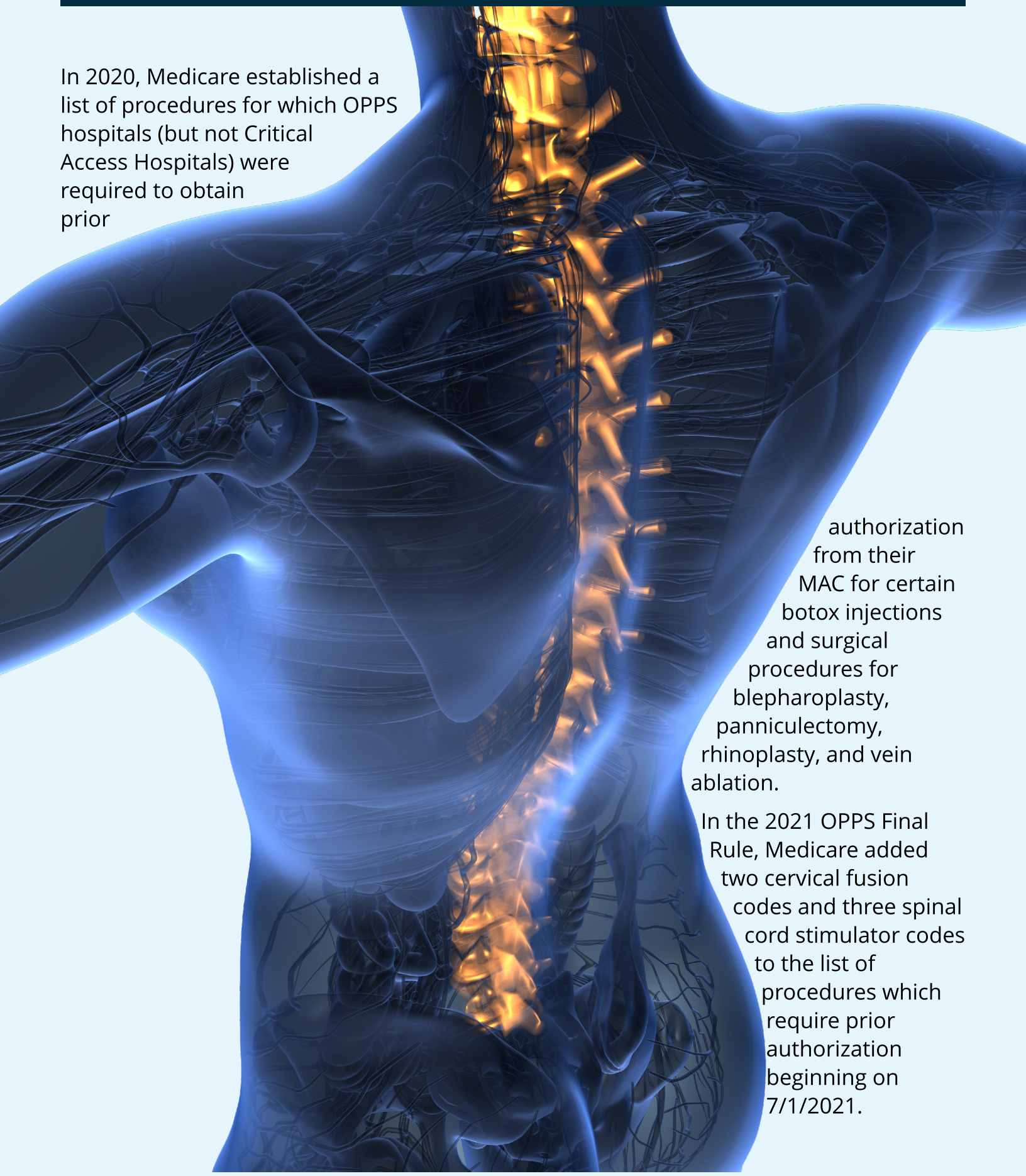
Meeting An Uncertain Future

With COVID-19 vaccinations becoming more widespread and infection rates and hospitalizations dropping, it is tempting to assume the worst of the pandemic is behind us. While this would obviously be ideal, there are no guarantees that virus variants won't create new and even more serious surges, or that hospital revenue will reach 2019 levels in the foreseeable future. Organizations should, therefore, push to rapidly implement new staffing, revenue cycle and pricing processes to position themselves for whatever tomorrow may bring.

Let **HFRI** help your organization supplement any staffing shortages, stay on top of accounts receivable inventory, identify where and how to maximize revenue and, if not completed yet, implement a price transparency program. Contact us today to learn how our services can help your organization overcome your financial challenges in 2021.

1. New AHA Report: Losses Deepen for Hospitals and Health Systems, American Hospital Association, June 30, 2020
2. Shaky U.S. Hospitals Risk Bankruptcy in Latest Covid Wave, Bloomberg, Oct. 14, 2020
3. National Hospital Flash Report, Kaufman Hall, January 2021
4. Hospital Bankruptcy Surge Looms as Virus Rages, Stimulus Lapses, Bloomberg Law, Oct. 28, 2020
5. Hospital Operating Margins Down Nearly 20% Since Start of Year Due to COVID-19, Report Says, Fierce Healthcare, Nov. 30, 2020
6. Update: How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?, Commonwealth Fund, Jan. 11, 2021
7. Analysis of Recent National Trends in Medicaid and CHIP Enrollment, Kaiser Family Foundation, Jan. 21, 2021
8. Limitations of the Program for Uninsured COVID-19 Patients Raises Concerns, Kaiser Family Foundation, Oct. 8, 2020

CMS ADDS SPINE PROCEDURES TO THE PRIOR AUTHORIZATION LIST



In 2020, Medicare established a list of procedures for which OPPS hospitals (but not Critical Access Hospitals) were required to obtain prior authorization from their MAC for certain botox injections and surgical procedures for blepharoplasty, panniculectomy, rhinoplasty, and vein ablation.

In the 2021 OPPS Final Rule, Medicare added two cervical fusion codes and three spinal cord stimulator codes to the list of procedures which require prior authorization beginning on 7/1/2021.

CMS ADDS SPINE PROCEDURES TO THE PRIOR AUTHORIZATION LIST

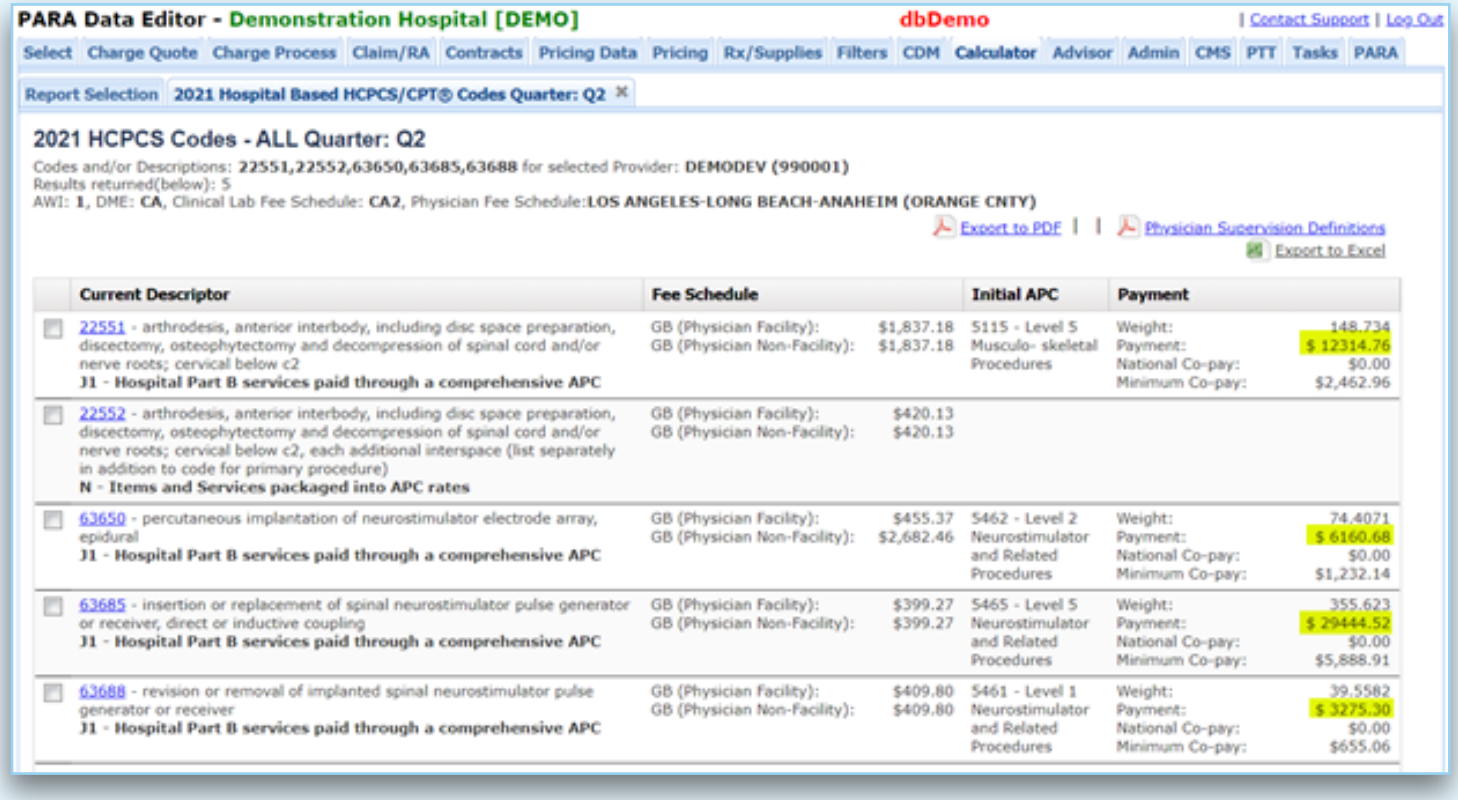
https://www.cms.gov/files/document/opd-services-require-prior-authorization.pdf

The following service categories comprise the list of hospital outpatient department services requiring prior authorization beginning for service dates on or after July 1, 2021:

- Cervical Fusion with Disc Removal
- Implanted Spinal Neurostimulators

CPT®	Description
22551	Fusion of spine bones with removal of disc at upper spinal column, anterior approach, complex, initial
22552	Fusion of spine bones with removal of disc in upper spinal column below second vertebra of neck , anterior approach, each additional interspace
63650	Implantation of spinal neurostimulator electrodes, accessed through the skin
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver

OPPS APC rates for the newly added procedures is available in the **PARA Data Editor** Calculator tab:



CMS ADDS SPINE PROCEDURES TO THE PRIOR AUTHORIZATION LIST

The addition of the neurostimulator procedures may actually help providers avoid billing high-cost procedures that do not meet arcane medical necessity requirements.

Recovery Audit Contractors (RACs) have taken their cue from Medicare's prior authorization additions.RACs submitted a proposal on April 6, 2021 for Medicare approval to audit spinal cord stimulator procedures for medical necessity.If and when this audit target is approved, hospitals can expect to receive documentation requests from RACs for high-cost spinal cord stimulator procedures:

https://www.cms.gov/node/1567681

The medical necessity requirements are found in both National Coverage Determination 160.2.

Here's a link and an excerpt from the NCD:

https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=240&DocID=160.7

"...No payment may be made for the implantation of dorsal column or depth brain stimulators or services and supplies related to such implantation, unless all of the conditions listed below have been met:

- The implantation of the stimulator is used only as a late resort (if not a last resort) for patients with chronic intractable pain
- With respect to item a [implanted peripheral nerve stimulators], other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated for the given patient
- Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation)
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow up of the patient (including that required to satisfy item c) must be available; and Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.

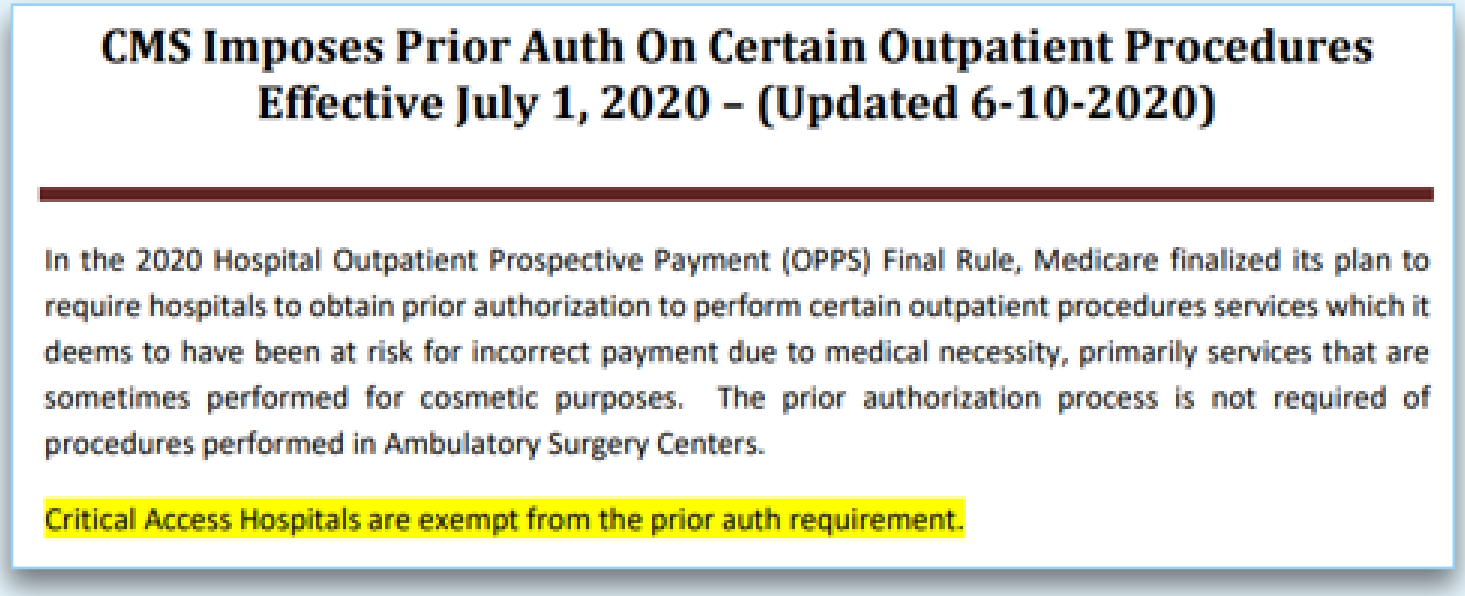
CMS ADDS SPINE PROCEDURES TO THE PRIOR AUTHORIZATION LIST

In addition, several MACs have established Local Coverage Determinations on Spinal Cord Stimulation for Chronic Pain which reiterate and elaborate upon the NCD requirements

MAC	LCD#	LCD Link
Novitas (JH & JL)	L35450	Local Coverage Determination for Spinal Cord Stimulation (Dorsal Column Stimulation) (L35450) (cms.gov)
First Coast (JN)	L36035	Local Coverage Determination for Spinal Cord Stimulation for Chronic Pain (L36035) (cms.gov)
Noridian (JF)	L36204	Local Coverage Determination for Spinal Cord Stimulators for Chronic Pain (L36204) (cms.gov)
Noridian (JE)	L35136	Local Coverage Determination for Spinal Cord Stimulators for Chronic Pain (L35136) (cms.gov)
Palmetto (JJ & JM)	L37632	Local Coverage Determination for Spinal Cord Stimulators for Chronic Pain (L37632) (cms.gov)

PARA's paper on the original prior authorization program established in 2020 is available to readers at the link below:

https://apps.para-hcfs.com/para/Documents/CMS%20Imposes%20Prior%20Auth%20For%20Some%20Outpatient%20Procedures%20Effective%207-1-2020%20updated.pdf



CMS Imposes Prior Auth On Certain Outpatient Procedures Effective July 1, 2020 – (Updated 6-10-2020)

In the 2020 Hospital Outpatient Prospective Payment (OPPS) Final Rule, Medicare finalized its plan to require hospitals to obtain prior authorization to perform certain outpatient procedures services which it deems to have been at risk for incorrect payment due to medical necessity, primarily services that are sometimes performed for cosmetic purposes. The prior authorization process is not required of procedures performed in Ambulatory Surgery Centers.

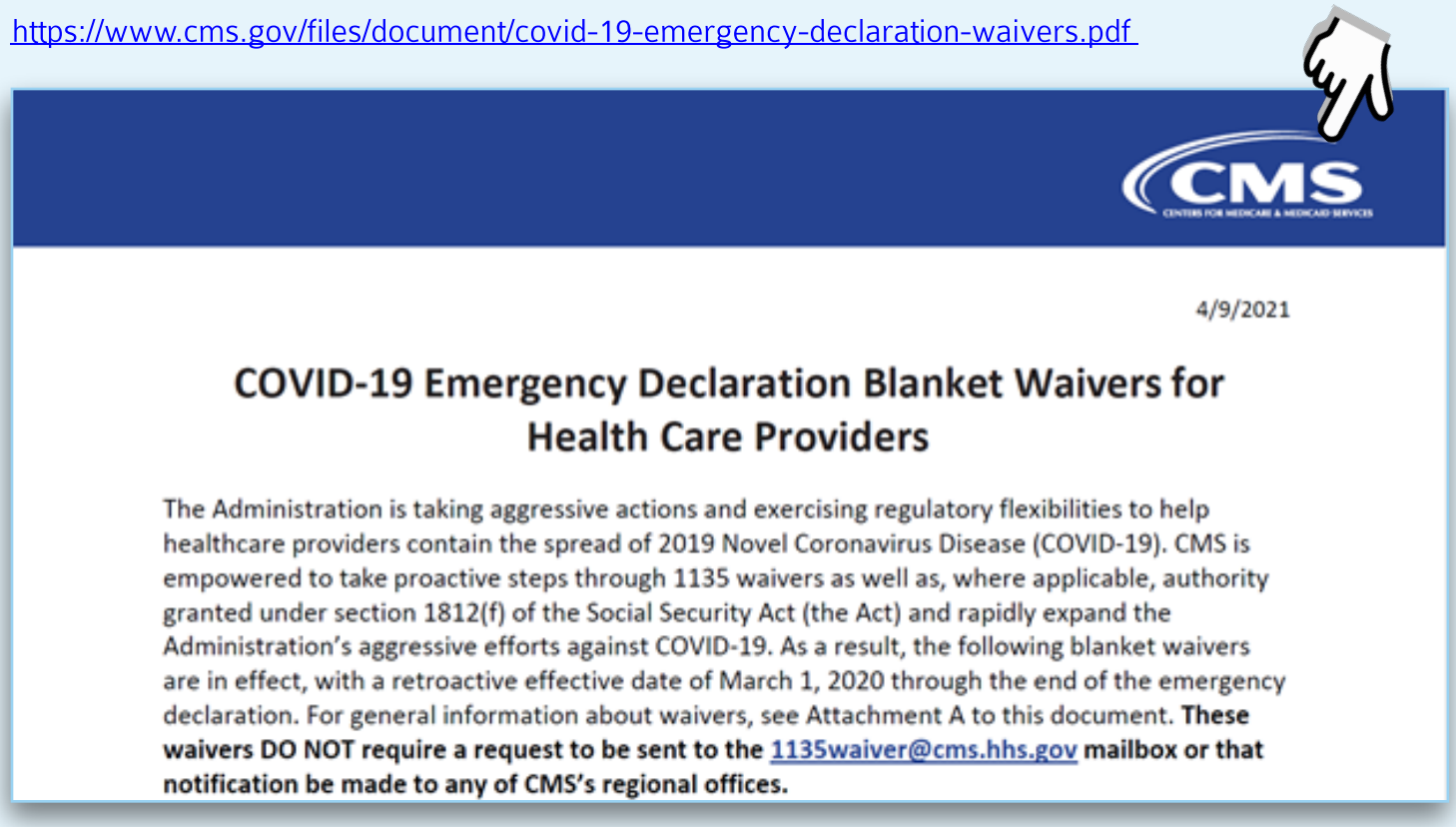
Critical Access Hospitals are exempt from the prior auth requirement.

CMS UPDATES LTC AND SNF EMERGENCY REGULATORY WAIVERS

On April 09, 2021, CMS added more regulatory flexibilities to help contain the spread of COVID-19, but they also discontinued several waiver provisions that affect Long Term Care Facilities (LTCs)and Skilled Nursing Facilities (SNFs.)

The new regulatory flexibilities were issued under 1135 waivers and were made to be effective retroactively beginning March 01, 2020 until the end of the emergency declaration.

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

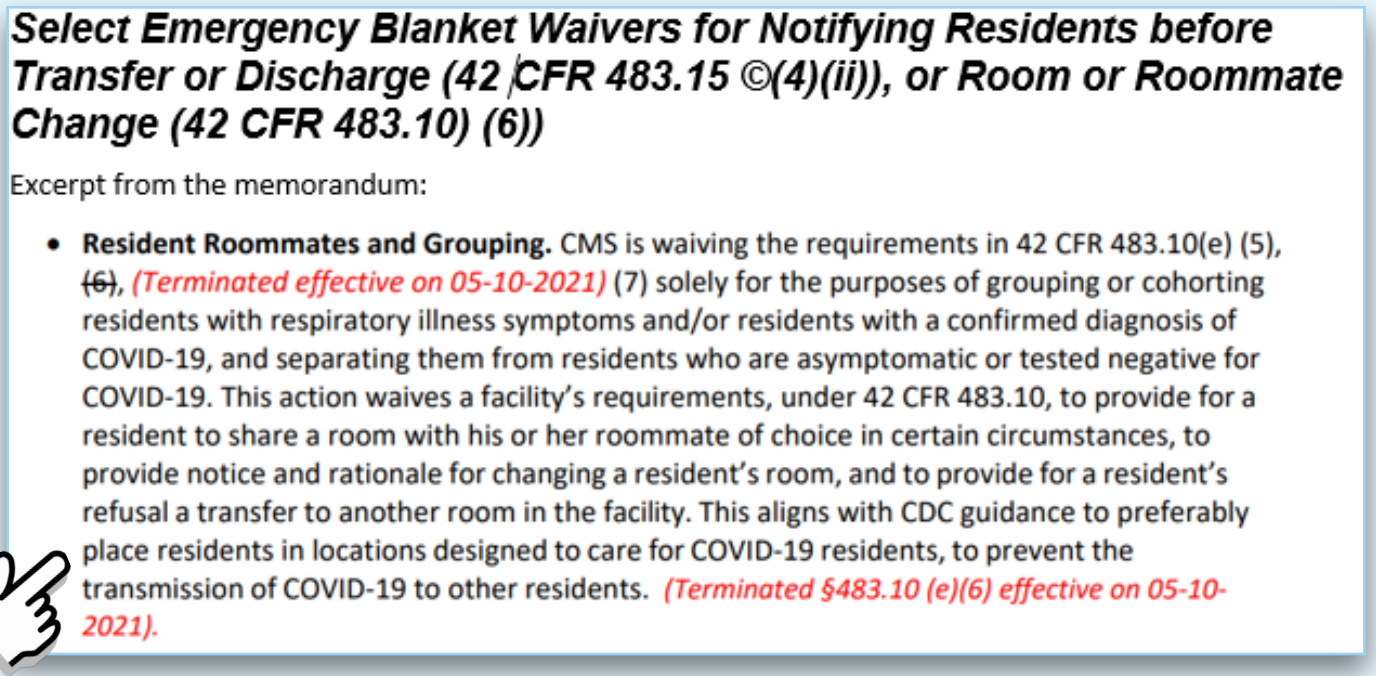


CMS

4/9/2021

COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

The Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers contain the spread of 2019 Novel Coronavirus Disease (COVID-19). CMS is empowered to take proactive steps through 1135 waivers as well as, where applicable, authority granted under section 1812(f) of the Social Security Act (the Act) and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are in effect, with a retroactive effective date of March 1, 2020 through the end of the emergency declaration. For general information about waivers, see Attachment A to this document. **These waivers DO NOT require a request to be sent to the 1135waiver@cms.hhs.gov mailbox or that notification be made to any of CMS's regional offices.**



Select Emergency Blanket Waivers for Notifying Residents before Transfer or Discharge (42 CFR 483.15 ©(4)(ii)), or Room or Roommate Change (42 CFR 483.10) (6))

Excerpt from the memorandum:

- **Resident Roommates and Grouping.** CMS is waiving the requirements in 42 CFR 483.10(e) (5), ~~(6)~~, *(Terminated effective on 05-10-2021)* (7) solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19. This action waives a facility's requirements, under 42 CFR 483.10, to provide for a resident to share a room with his or her roommate of choice in certain circumstances, to provide notice and rationale for changing a resident's room, and to provide for a resident's refusal a transfer to another room in the facility. This aligns with CDC guidance to preferably place residents in locations designed to care for COVID-19 residents, to prevent the transmission of COVID-19 to other residents. *(Terminated §483.10 (e)(6) effective on 05-10-2021).*

CMS UPDATES LTC AND SNF EMERGENCY REGULATORY WAIVERS

This blanket waiver was intended to assist nursing homes to take swift action to implement transmission-based precautions and cohort residents who have been exposed or potentially exposed to COVID-19, CMS waived requirements to provide advance notice prior to transfers or discharges and prior to room or roommate changes.

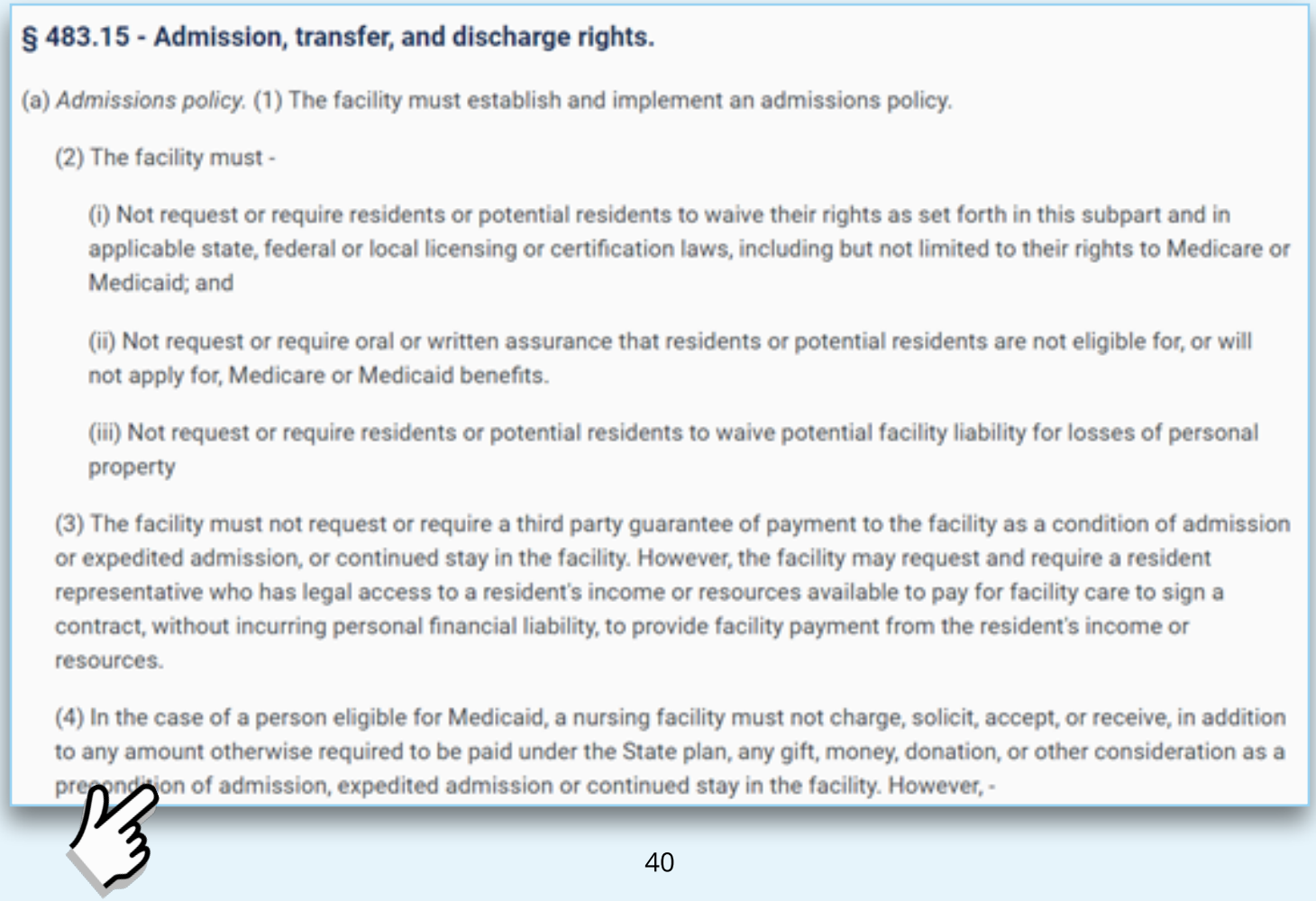
Prior to the emergency blanket waiver, facilities were required to provide notice when transferring or discharging residents. Facilities were required to provide notice of the transfer or discharge to the resident/representative 30 days in advance, or as soon as practicable prior to the transfer or discharge.

At this time, CMS believes nursing homes have developed practices that have made them able to efficiently cohort residents and provide the required notice in advance. In view of this, facilities are now required to resume providing notice as required in the regulations:

- With 30 days advanced notice, or as soon as practicable before the transfer or discharge of a resident; and
- Before a room or roommate change

Providers please note: CMS is only ending the waivers at (42CFR 483.10) (6) for providing written notice before a room/roommate change, and at 42CFR 483.15(c) (4)(ii) for timing of notification of transfer or discharge. All other related waivers, which continue to allow facilities to transfer or discharge, and change rooms for the sole purpose of cohorting remain in effect.

https://www.govregs.com/regulations/title42_chapterIV-i3_part483_subpartB_section483.15



§ 483.15 - Admission, transfer, and discharge rights.

(a) *Admissions policy.* (1) The facility must establish and implement an admissions policy.

(2) The facility must -

(i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and

(ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property

(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However, -

CMS UPDATES LTC AND SNF EMERGENCY REGULATORY WAIVERS

Emergency Blanket Waiver for Care Planning Requirements

Excerpt from the memorandum:

- In § 483.10, we are only waiving the requirement, under § 483.10(c)(5), that a facility provide advance notification of options relating to the transfer or discharge to another facility. Otherwise, all requirements related to § 483.10 are not waived. Similarly, in § 483.15, we are only waiving the requirement, under § 483.15(c)(3), ~~(c)(4)(ii)~~ *(Terminated effective on 05-10-2021)*, (c)(5)(i) and (iv), and (d), for the written notice of transfer or discharge to be provided before the transfer or discharge. This notice must be provided as soon as practicable. *(Terminated §483.15(c) (4)(ii) effective on 05-10-2021)*

- ~~In § 483.21, we are only waiving the timeframes for certain care planning requirements for residents who are transferred or discharged for the purposes explained in 1–3 above. Receiving facilities should complete the required care plans as soon as practicable, and we expect receiving facilities to review and use the care plans for residents from the transferring facility, and adjust as necessary to protect the health and safety of the residents the apply to.~~ *(Terminated effective 05-10-2021)*

Currently, Federal Regulations require a nursing home complete a baseline care plan and comprehensive care plan within 48 hours and seven days of admission to the facility.

In light of the PHE, CMS intended this waiver to aid Nursing Home Facilities implement transmission-based precautions and cohort residents who have been exposed or potentially exposed to COVID-19. CMS waived these requirements when transferring or discharging residents to another long-term care facility requirements for the certain cohorting purposes of admission, after a comprehensive MDS.

CMS believes that nursing homes have developed processes for completing these important care planning tasks which is the CMS rationale for ending this emergency blanket waiver for 42 CFR 483.21 (a)(1)(i), (a)(2)(i) and (b)(2)(i).

https://www.govregs.com/regulations/title42_chapterIV-i3_part483_subpartB_section483.21

§ 483.21 - Comprehensive person-centered care planning.

(a) *Baseline care plans.* (1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must -

(i) Be developed within 48 hours of a resident's admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:

(A) Initial goals based on admission orders.

(B) Physician orders.

(C) Dietary orders.

(D) Therapy services.

(E) Social services.

(F) PASARR recommendation, if applicable.

CMS UPDATES LTC AND SNF EMERGENCY REGULATORY WAIVERS

Emergency Blanket Waiver of Minimum Data Set (MDS) Timeframe Requirements

Excerpt from the memorandum:

- ~~**Reporting Minimum Data Set.** CMS is waiving 42 CFR 483.20 to provide relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.~~ *(Terminated effective 05-10-2021)*

Currently, Federal Regulations require a nursing home complete a baseline care plan and comprehensive care plan within 48 hours and seven days of admission to the facility.

In light of the PHE, CMS intended this waiver to aid Nursing Home Facilities implement transmission-based precautions and cohort residents who have been exposed or potentially exposed to COVID-19. CMS waived these requirements when transferring or discharging residents to another long-term care facility requirements for the certain cohorting purposes of admission, after a comprehensive MDS.

CMS believes that nursing homes have developed processes for completing these important care planning tasks which is the CMS rationale for ending this emergency blanket waiver for 42 CFR 483.21 (a)(1)(i), (a)(2)(i) and (b)(2)(i).

https://www.govregs.com/regulations/title42_chapterIV-i3_part483_subpartB_section483.21

§ 483.21 - Comprehensive person-centered care planning.

(a) *Baseline care plans.* (1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must -

(i) Be developed within 48 hours of a resident's admission.

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:

(A) Initial goals based on admission orders.

(B) Physician orders.

(C) Dietary orders.

(D) Therapy services.

(E) Social services.

(F) PASARR recommendation, if applicable.

CMS UPDATES LTC AND SNF EMERGENCY REGULATORY WAIVERS

Note:the waiver at 42CFR 483.20(k) relating to Pre-Admission Screening and Annual Resident Preview (PASARR) will **NOT** end at this time (see link below):

https://www.govregs.com/regulations/title42_chapterIV-i3_part483_subpartB_section483.20

(k) *Preadmission screening for individuals with a mental disorder and individuals with intellectual disability.* (1) A nursing facility must not admit, on or after January 1, 1989, any new resident with -

(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission -

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

(2) *Exceptions.* For purposes of this section -

(i) The preadmission screening program under paragraph (k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual -

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) *Definition.* For purposes of this section -

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder as defined in § 483.102(b)(1).

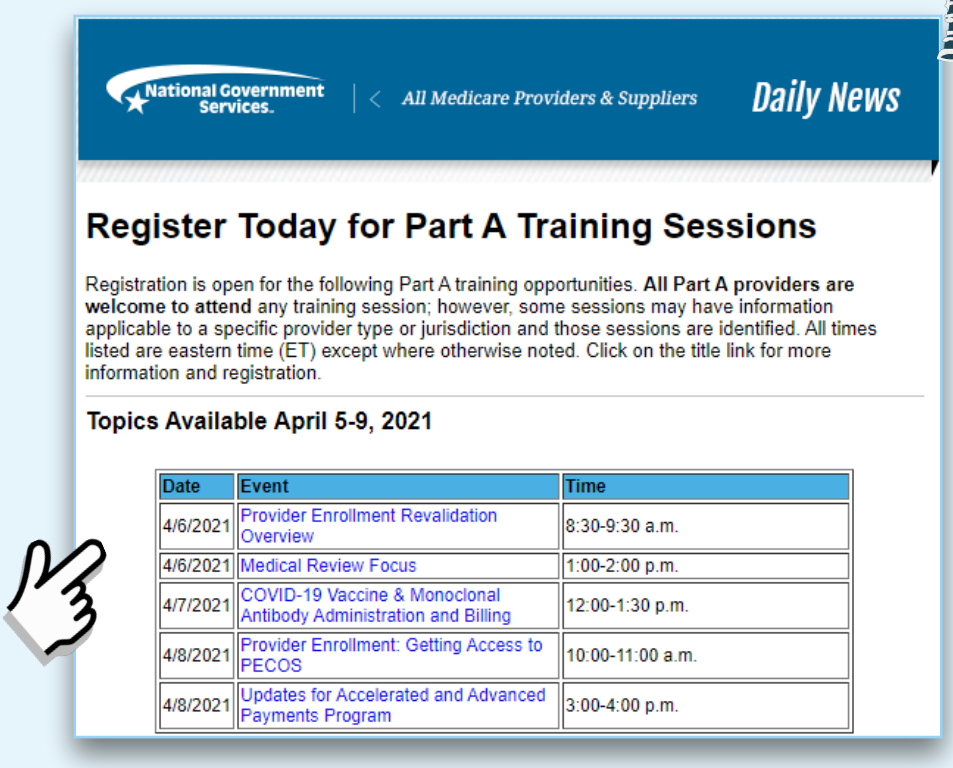
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in § 483.102(b)(3) or is a person with a related condition as described in § 435.1010 of this chapter.

(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applic promptly after a significant change in the mental or physical condition of a resident who has a mental disorder o intellectual disability for resident review.

NSG OFFERS FREE MEDICARE PART A BILLER TRAINING

PARA reminds our readers that National Government Services (NGS) offers Medicare Part A web-based training sessions to all Part A providers free of cost.A list of the upcoming sessions is available through the following link:

http://view.email.ngsmedicare.com/?qs=3eb841224ce3455aef5739714fdecca836161f6406ffaa1d7d507e327278090c149804501a1c476a6f951dee71284d554b292171f77f16e71a73906837be352e790b14558b766b00b045b2e44a07e8105c166d67e82ae5a5



National Government Services | All Medicare Providers & Suppliers — Daily News

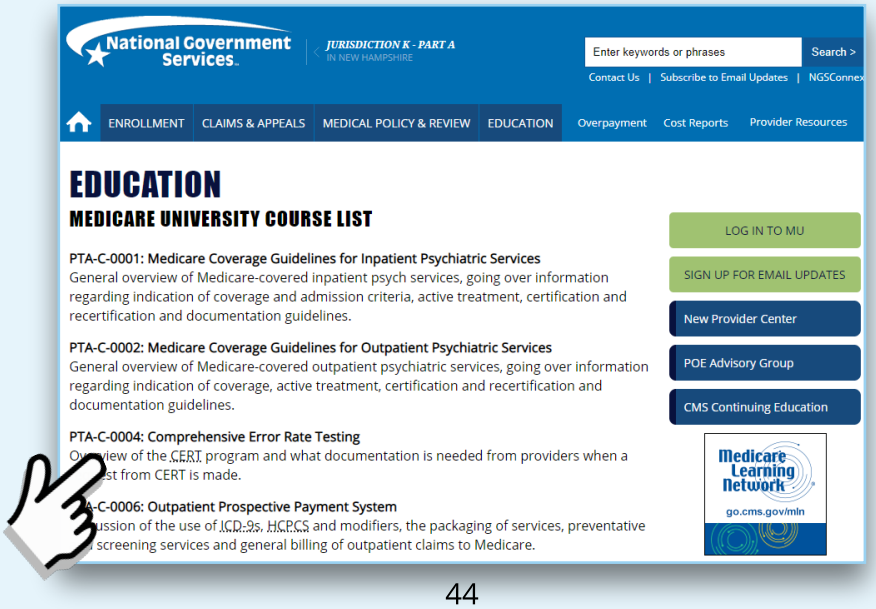
Register Today for Part A Training Sessions

Registration is open for the following Part A training opportunities. **All Part A providers are welcome to attend** any training session; however, some sessions may have information applicable to a specific provider type or jurisdiction and those sessions are identified. All times listed are eastern time (ET) except where otherwise noted. Click on the title link for more information and registration.

Topics Available April 5-9, 2021

Date	Event	Time
4/6/2021	Provider Enrollment Revalidation Overview	8:30-9:30 a.m.
4/6/2021	Medical Review Focus	1:00-2:00 p.m.
4/7/2021	COVID-19 Vaccine & Monoclonal Antibody Administration and Billing	12:00-1:30 p.m.
4/8/2021	Provider Enrollment: Getting Access to PECOS	10:00-11:00 a.m.
4/8/2021	Updates for Accelerated and Advanced Payments Program	3:00-4:00 p.m.

NGS also offers computer-based training through its Medicare University portal.To access these sessions, you must register and create a log in. Once logged in, registrars have access to thousands of courses.



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EDUCATION

MEDICARE UNIVERSITY COURSE LIST

PTA-C-0001: Medicare Coverage Guidelines for Inpatient Psychiatric Services
General overview of Medicare-covered inpatient psych services, going over information regarding indication of coverage and admission criteria, active treatment, certification and recertification and documentation guidelines.

PTA-C-0002: Medicare Coverage Guidelines for Outpatient Psychiatric Services
General overview of Medicare-covered outpatient psychiatric services, going over information regarding indication of coverage, active treatment, certification and recertification and documentation guidelines.

PTA-C-0004: Comprehensive Error Rate Testing
Overview of the CERT program and what documentation is needed from providers when a request from CERT is made.

PTA-C-0006: Outpatient Prospective Payment System
Discussion of the use of ICD-9s, HCPCS and modifiers, the packaging of services, preventative and screening services and general billing of outpatient claims to Medicare.

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New Provider Center

POE Advisory Group

CMS Continuing Education

Medicare Learning Network — go.cms.gov/mln

COVID-19 FUNERAL ASSISTANCE PROGRAM

As part of the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA) of 2021 and the American Rescue Plan Act of 2021, FEMA may aid with funeral expenses that occurred after January 20, 2020.Applications opened on **April 12, 2021**, to "ease of some of the financial stress and burden caused by the virus."

Applicants will need to provide a death certificate that indicates the patient died because of coronavirus while in the United States or U.S. territories.The patient did not have to be a United States citizen, non-citizen, or qualified alien.

The COVID-19 Funeral Assistance Line Number:

844-684-6333|TTY:800-462-7585

A U.S. citizen, non-citizen, or qualified alien who incurred funeral and related expenses will need to provide receipts or contracts showing the responsible party.

Expenses may include but are not limited to:

- Transfer of remains
- Marker or headstone
- Clergy or officiant services
- Cremation or burial costs
- Funeral ceremony arrangements
- Funeral home equipment or staff
- Costs associated with producing and certifying death certificates
- Transportation of up to persons to identify the deceased individual
- Casket or urn

Additionally, applicants will be asked for the following information, so FEMA suggest preparing these before calling:

- Deceased individual's SSN, date of birth, where the individual passed away
- Information on donations, grants, or other funeral assistance received
- Routing and account number for the applicant for direct deposit of funds

Qualified individuals may apply for assistance for more than one person who died from coronavirus.

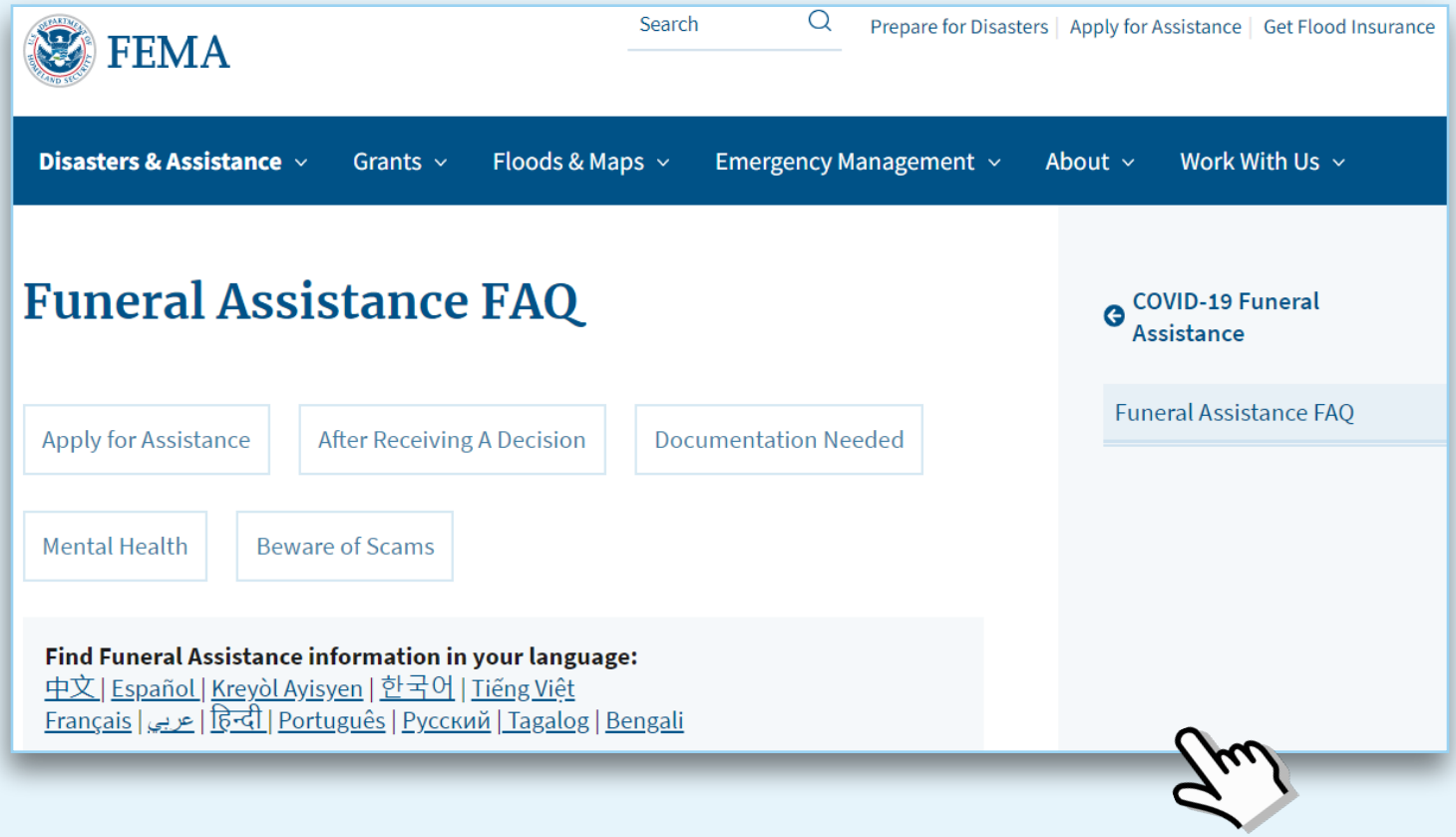
Financial assistance is limited to a max of $9,000 per funeral and a maximum of $35,500 per application per state, and life insurance proceeds are not considered a duplication of Funeral Assistance benefits. Pre-planned and pre-paid burials or funerals are not eligible for reimbursement.

COVID-19 FUNERAL ASSISTANCE PROGRAM

FEMA will not accept online applications but has set up a toll-free phone number for questions and complete an application with an agent.A caller may experience busy signals as FEMA works through technical issues, but, currently, there is no deadline to apply.

FEMA offers a FAQ page at the following site:

https://www.fema.gov/disasters/coronavirus/economic/funeral-assistance/faq

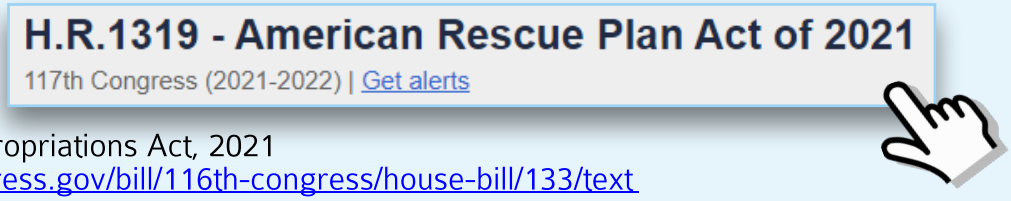


References:

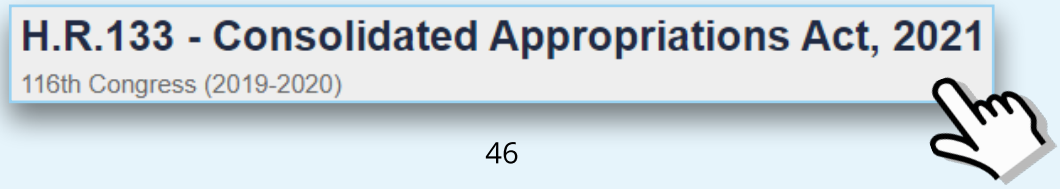
Congress.gov –

American Rescue Plan Act of 2021

https://www.congress.gov/bill/117th-congress/house-bill/1319

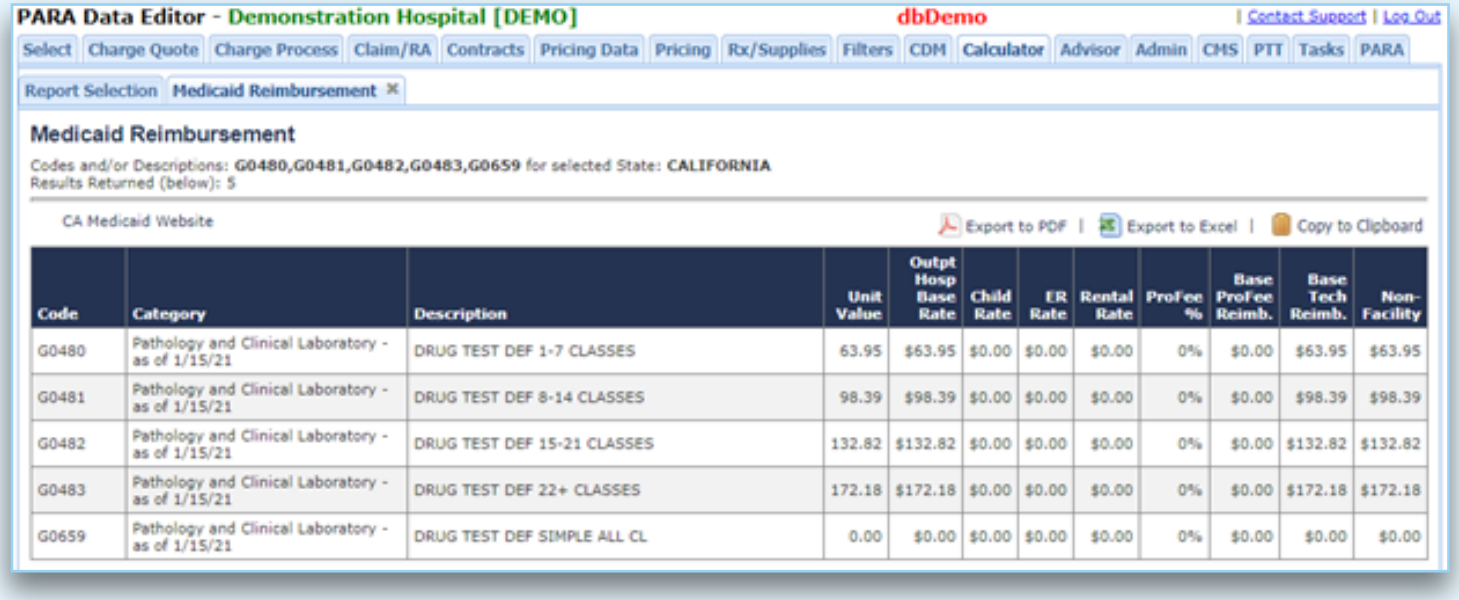


Consolidated Appropriations Act, 2021
https://www.congress.gov/bill/116th-congress/house-bill/133/text



MEDI-CAL UPDATE: FREQUENCY LIMIT UPDATES

Effective retroactively for dates of service on or after March 1st, 2019 the frequency limits for the below listed HCPCS codes have been updated from once per week to once per day. These HCPCS codes do require a Treatment Authorization Request (TAR) or Service Authorization Request (SAR).



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

Report Selection | Medicaid Reimbursement

Medicaid Reimbursement

Codes and/or Descriptions: **G0480,G0481,G0482,G0483,G0659** 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	Outpt Hosp Base Rate	Child Rate	ER Rate	Rental Rate	Prof-ee %	Base Prof-ee Reimb.	Base Tech Reimb.	Non-Facility
G0480	Pathology and Clinical Laboratory - as of 1/15/21	DRUG TEST DEF 1-7 CLASSES	63.95	$63.95	$0.00	$0.00	$0.00	0%	$0.00	$63.95	$63.95
G0481	Pathology and Clinical Laboratory - as of 1/15/21	DRUG TEST DEF 8-14 CLASSES	98.39	$98.39	$0.00	$0.00	$0.00	0%	$0.00	$98.39	$98.39
G0482	Pathology and Clinical Laboratory - as of 1/15/21	DRUG TEST DEF 15-21 CLASSES	132.82	$132.82	$0.00	$0.00	$0.00	0%	$0.00	$132.82	$132.82
G0483	Pathology and Clinical Laboratory - as of 1/15/21	DRUG TEST DEF 22+ CLASSES	172.18	$172.18	$0.00	$0.00	$0.00	0%	$0.00	$172.18	$172.18
G0659	Pathology and Clinical Laboratory - as of 1/15/21	DRUG TEST DEF SIMPLE ALL CL	0.00	$0.00	$0.00	$0.00	$0.00	0%	$0.00	$0.00	$0.00

There is no action required on the behalf of providers. An Erroneous Payment Correction (EPC) will be processed automatically for affected claims.

https://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/cah202104.aspx

Medi-Cal Update

Clinics and Hospitals | April 2021 | Bulletin 559

Print Medi-Cal Update

Contents

CMS REPAYMENT OF COVID-19 ACCELERATED AND ADVANCED PAYMENTS

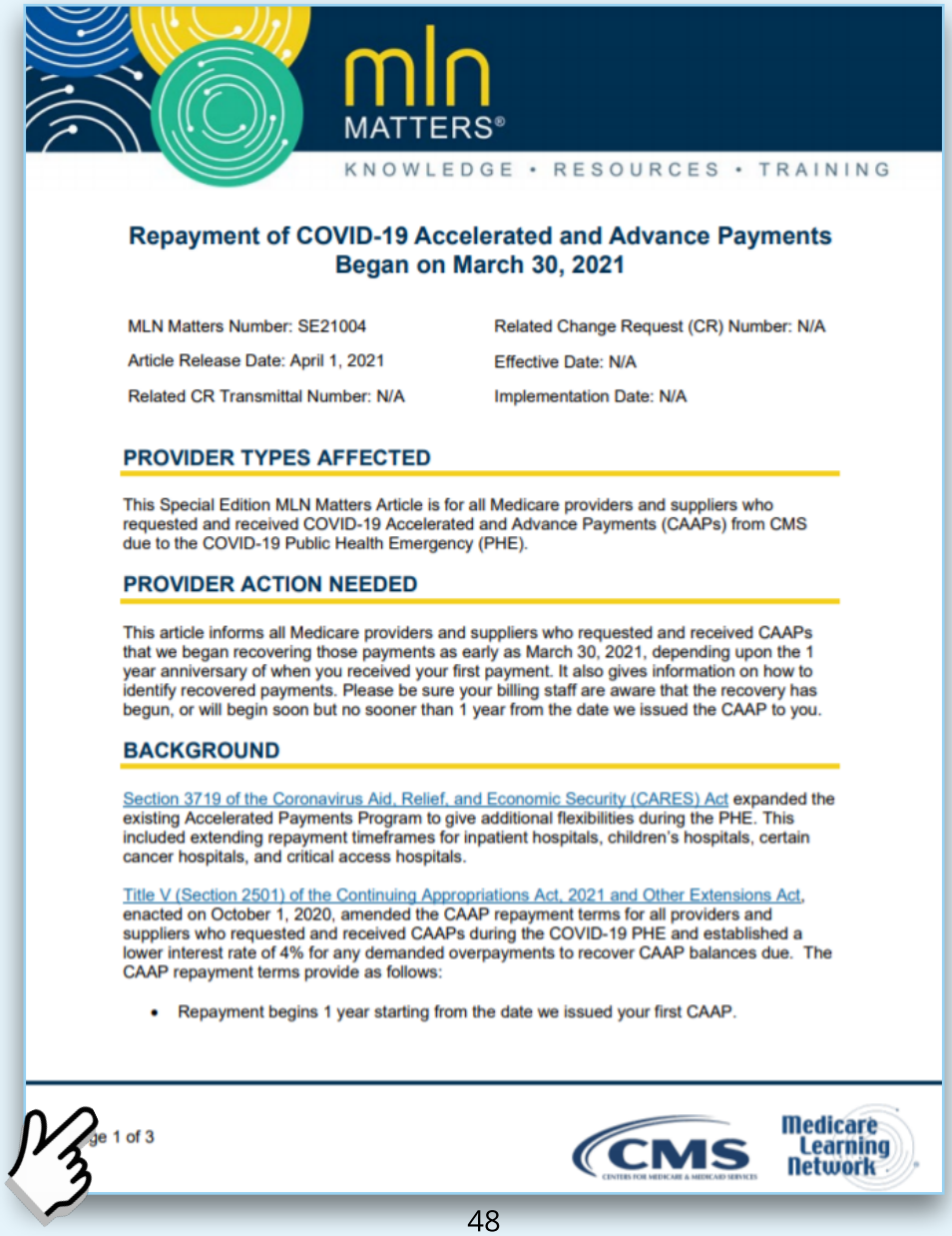
On April 01, 2021, CMS released a Special Edition Transmittal to alert all Medicare providers and suppliers who requested and were issued Accelerated an Advance Payments (CAAPs) from CMS due to the COVID-19 Public Health Emergency (PHE).

The purpose of the CMS Transmittal is to alert all Medicare providers and suppliers who received CAAPs, that CMS began the recovery of those payments on March 30, 2021. The actual recovery date depends on the first anniversary of the receipt of the first payment.

Further, CMS will show the recoupment on the remittance advices issued for Medicare Part A and B claims that are processed after the 1styear anniversary of issuing the first payment. The recoupment will appear as an adjustment in the Provider-Level Balance (PLB) section of the remittance advice.

Institutional providers entitled to receive Periodic Interim Payments (PIP) should note, recoupment will be from issued (PIPs) rather than in reconciliation and settlement of final cost reports.

https://www.cms.gov/files/document/se21004.pdf



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Repayment of COVID-19 Accelerated and Advance Payments Began on March 30, 2021

MLN Matters Number: SE21004 | Related Change Request (CR) Number: N/A

Article Release Date: April 1, 2021 | Effective Date: N/A

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

PROVIDER TYPES AFFECTED

This Special Edition MLN Matters Article is for all Medicare providers and suppliers who requested and received COVID-19 Accelerated and Advance Payments (CAAPs) from CMS due to the COVID-19 Public Health Emergency (PHE).

PROVIDER ACTION NEEDED

This article informs all Medicare providers and suppliers who requested and received CAAPs that we began recovering those payments as early as March 30, 2021, depending upon the 1 year anniversary of when you received your first payment. It also gives information on how to identify recovered payments. Please be sure your billing staff are aware that the recovery has begun, or will begin soon but no sooner than 1 year from the date we issued the CAAP to you.

BACKGROUND

Section 3719 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act expanded the existing Accelerated Payments Program to give additional flexibilities during the PHE. This included extending repayment timeframes for inpatient hospitals, children's hospitals, certain cancer hospitals, and critical access hospitals.

Title V (Section 2501) of the Continuing Appropriations Act, 2021 and Other Extensions Act, enacted on October 1, 2020, amended the CAAP repayment terms for all providers and suppliers who requested and received CAAPs during the COVID-19 PHE and established a lower interest rate of 4% for any demanded overpayments to recover CAAP balances due. The CAAP repayment terms provide as follows:

- Repayment begins 1 year starting from the date we issued your first CAAP.

ge 1 of 3

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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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!**

mlnconnects
Official CMS news from the Medicare Learning Network

Thursday, April 29, 2021

News

- Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS

Compliance

- Cardiac Device Credits: Medicare Billing

Claims, Pricers, & Codes

- Coordination of Benefits: Parts A & B Crossover Claims Issue

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- Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Code 87636

Publications

- SBIRT Services
- NPI: What You Need to Know — Revised

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Subject NPI: What You Need to Know

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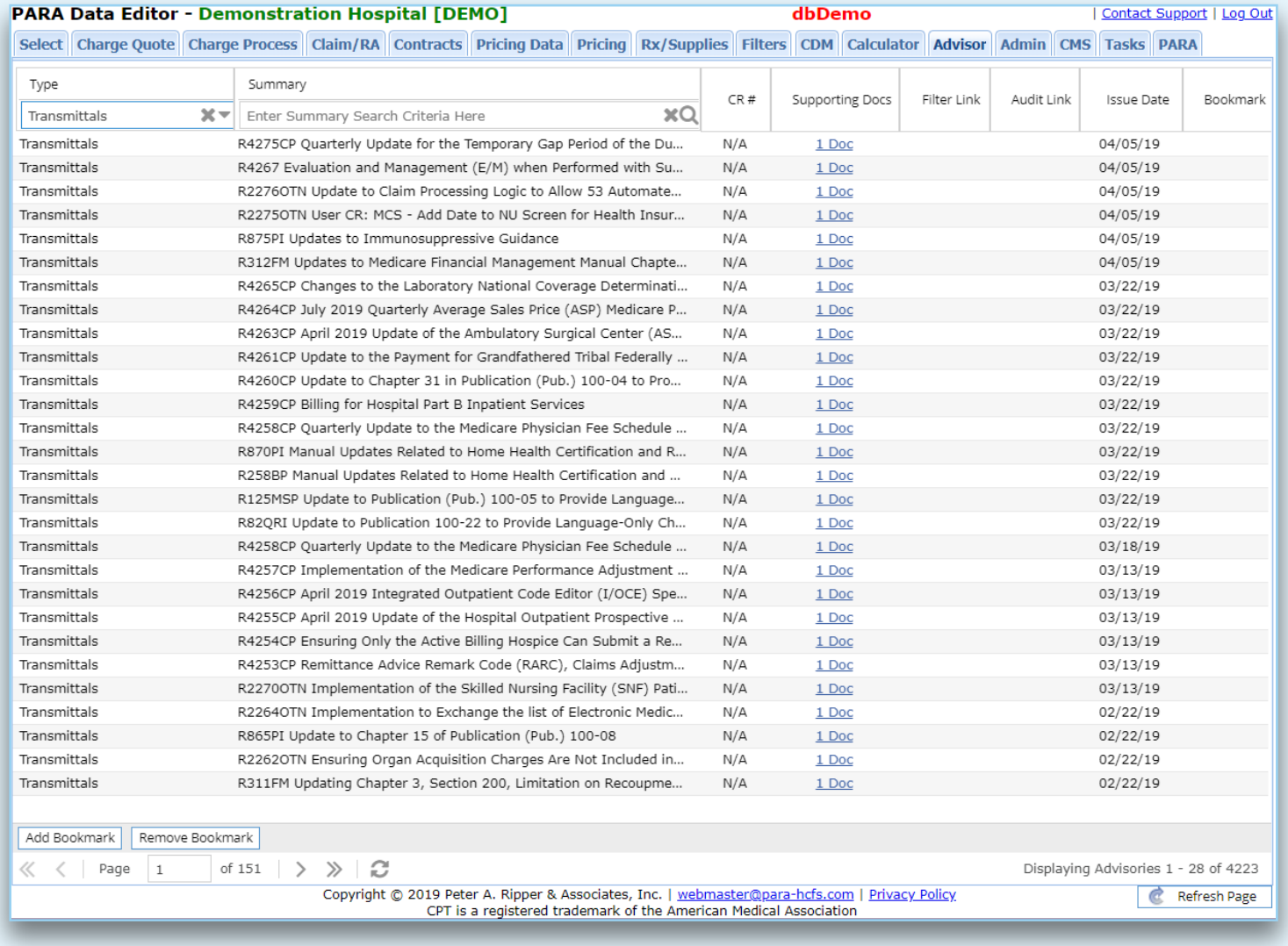

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Transmittals	R4267 Evaluation and Management (E/M) when Performed with Su...	N/A	1 Doc			04/05/19	
Transmittals	R2276OTN Update to Claim Processing Logic to Allow 53 Automate...	N/A	1 Doc			04/05/19	
Transmittals	R2275OTN User CR: MCS - Add Date to NU Screen for Health Insur...	N/A	1 Doc			04/05/19	
Transmittals	R875PI Updates to Immunosuppressive Guidance	N/A	1 Doc			04/05/19	
Transmittals	R312FM Updates to Medicare Financial Management Manual Chapte...	N/A	1 Doc			04/05/19	
Transmittals	R4265CP Changes to the Laboratory National Coverage Determinati...	N/A	1 Doc			03/22/19	
Transmittals	R4264CP July 2019 Quarterly Average Sales Price (ASP) Medicare P...	N/A	1 Doc			03/22/19	
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Transmittals	R4261CP Update to the Payment for Grandfathered Tribal Federally ...	N/A	1 Doc			03/22/19	
Transmittals	R4260CP Update to Chapter 31 in Publication (Pub.) 100-04 to Pro...	N/A	1 Doc			03/22/19	
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Transmittals	R4258CP Quarterly Update to the Medicare Physician Fee Schedule ...	N/A	1 Doc			03/22/19	
Transmittals	R870PI Manual Updates Related to Home Health Certification and R...	N/A	1 Doc			03/22/19	
Transmittals	R258BP Manual Updates Related to Home Health Certification and ...	N/A	1 Doc			03/22/19	
Transmittals	R125MSP Update to Publication (Pub.) 100-05 to Provide Language...	N/A	1 Doc			03/22/19	
Transmittals	R82QRI Update to Publication 100-22 to Provide Language-Only Ch...	N/A	1 Doc			03/22/19	
Transmittals	R4258CP Quarterly Update to the Medicare Physician Fee Schedule ...	N/A	1 Doc			03/18/19	
Transmittals	R4257CP Implementation of the Medicare Performance Adjustment ...	N/A	1 Doc			03/13/19	
Transmittals	R4256CP April 2019 Integrated Outpatient Code Editor (I/OCE) Spe...	N/A	1 Doc			03/13/19	
Transmittals	R4255CP April 2019 Update of the Hospital Outpatient Prospective ...	N/A	1 Doc			03/13/19	
Transmittals	R4254CP Ensuring Only the Active Billing Hospice Can Submit a Re...	N/A	1 Doc			03/13/19	
Transmittals	R4253CP Remittance Advice Remark Code (RARC), Claims Adjustm...	N/A	1 Doc			03/13/19	
Transmittals	R2270OTN Implementation of the Skilled Nursing Facility (SNF) Pati...	N/A	1 Doc			03/13/19	
Transmittals	R2264OTN Implementation to Exchange the list of Electronic Medic...	N/A	1 Doc			02/22/19	
Transmittals	R865PI Update to Chapter 15 of Publication (Pub.) 100-08	N/A	1 Doc			02/22/19	
Transmittals	R2262OTN Ensuring Organ Acquisition Charges Are Not Included in...	N/A	1 Doc			02/22/19	
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Update to Rural Health Clinic (RHC) Payment Limits

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

Related CR Release Date: May 4, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10780OTN | Implementation Date: April 5, 2021

Note: We revised this article to reflect a revised CR 12185. In the article, we made minor changes to clarify the AIR is also the payment per visit (pages 1 and 2), added reference to a technical correction to section 1833 (f) of the Social Security Act (page 2), and we replaced the entire section on PB RHCs in a hospital with less than 50 beds (pages 2-4). We also changed the CR release date, transmittal number, and the web address of the CR.

Provider Types Affected

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

Provider Action Needed

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

Background

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

Also, under Section 1833(f) of the Act, an RHC that is Provider-Based (PB) to a hospital with fewer than 50 beds is exempt from the national payment limit per visit. That is, a PB RHC's AIR (also referred to as payment per visit) is based on their average allowable costs determined at cost report settlement.

In the interim final rule with comment, published in the May 8, 2020, Federal Register (85 FR 27550-27529), we implemented a policy that excludes temporarily added surge capacity beds due to the Public Health Emergency (PHE) for the COVID-19 pandemic (defined at Section

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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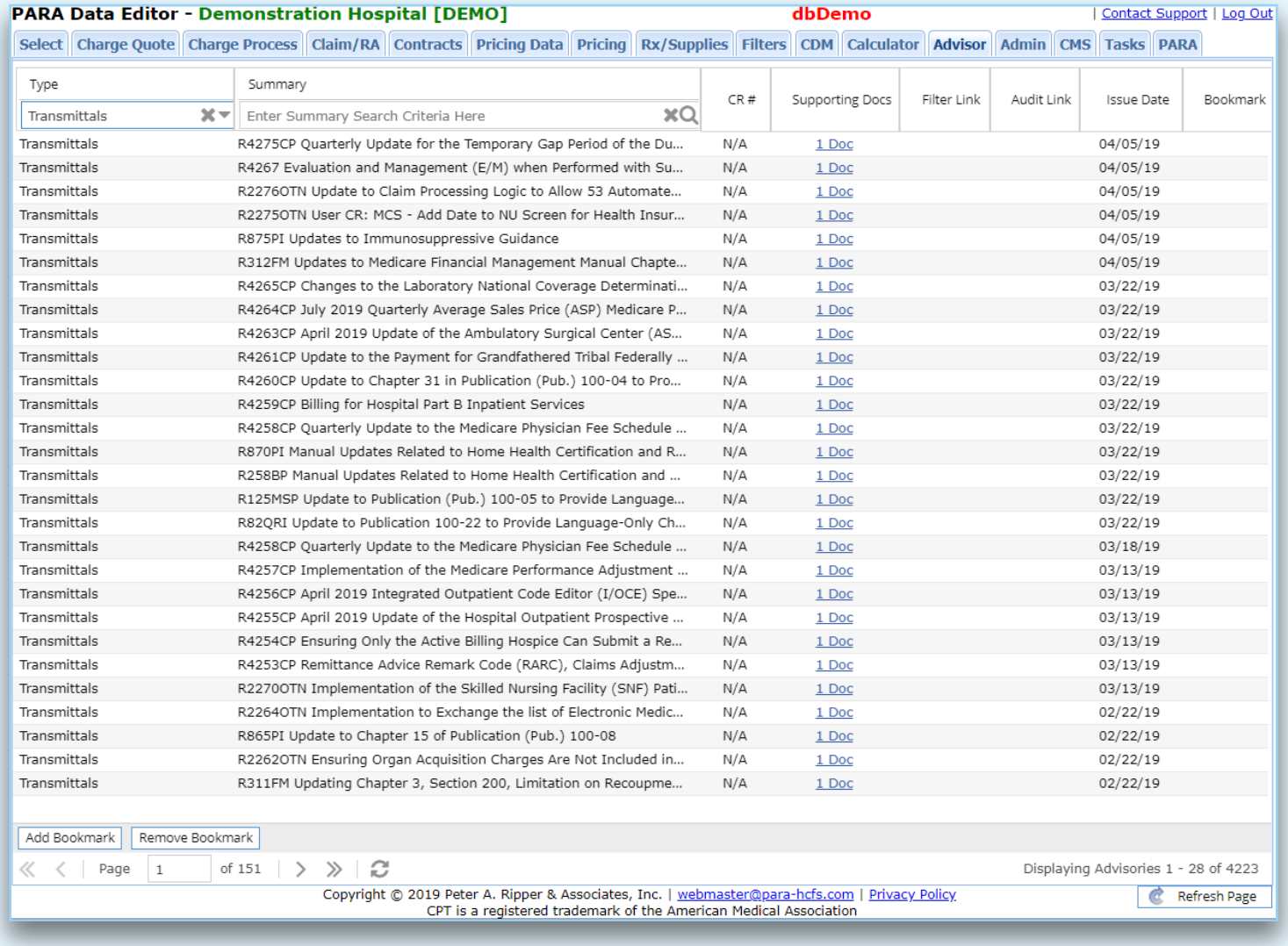

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CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10780	**Date: May 4, 2021**
	Change Request 12185

Transmittal 10679, dated March 16, 2021, is being rescinded and replaced by Transmittal 10780, dated, May 4, 2021 to revise the background and policy sections. This correction also revises Business Requirement (BR) 12185.2 and adds BR 12185.2.1. All other information remains the same.

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

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

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

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

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

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

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

IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R10742CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10742	**Date: May 3, 2021**
	Change Request 12275

SUBJECT: Revisions of Sections 30.6.1(B), 30.6.12, and 30.6.13(H) of Chapter 12 of the Medicare Claims Policy Manual

I. SUMMARY OF CHANGES: The purpose of this CR is to revise sections 30.6.1, 30.6.12, and 30.6.13 of the Medicare Claims Policy Manual (Internet Only Manual (IOM) Pub. 100-04) in response to a petition received in January by the U.S. Department of Health and Human Services (HHS) pursuant to the HHS Good Guidance Practices Regulation (85 Fed. Reg. 78,770 and 45 C.F.R. § 1.5(a)(1)), CMS is revising the following sections of the Centers for Medicare & Medicaid Services ("CMS") Claims Processing Manual (Pub. 100-04), Chapter 12:

- Section 30.6.1 Selection of Level of Evaluation and Management Service, (Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16); B. Selection of Level of Evaluation and Management Service; Split/Shared E/M Service.
- Section 30.6.12 Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292) (Rev. 2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01- 2012 - ASC X12, Implementation: 08-25-2014 - ASC X12; Upon Implementation of ICD-10), Critical Care Services (Codes 99291-99292).
- Section 30.6.13 Nursing Facility Services, (Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11); H. Split/Shared E/M Visit.

CMS plans to address the topics therein through notice-and-comment rulemaking.

EFFECTIVE DATE: May 9, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 9, 2021

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

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/30/6.1/Selection of Level of Evaluation and Management Service
R	12/30/6.12/Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)
R	12/30/6.13/Nursing Facility Services

III. FUNDING:

The link to this Transmittal R6P242I

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

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

Transmittal 6 **Date: April 30, 2021**

HEADER SECTION NUMBERS	NEW PAGES	REPLACE PAGES
Table of Contents	42-1 - 42-2 (2 pp.)	42-1 - 42-2 (2 pp.)
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4295 (Cont.) - 4295 (Cont.)	42-503 - 42-510 (8 pp.) 42-513 - 42-516 (4 pp.) 42-525 - 42-534 (10 pp.)	42-503 - 42-510 (8 pp.) 42-513 - 42-516 (4 pp.) 42-525 - 42-534 (10 pp.)

NEW COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: ESRD changes effective for cost reporting periods ending on or after March 31, 2021.

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

Revisions include:

Worksheet S, Part III--Assigned line numbers to existing data fields to facilitate capturing information in the electronic cost report (ECR) file.

Worksheet A--Revised line 21 to report the cost of COVID-19 vaccines and monoclonal antibody products to treat COVID-19 in accordance with §3713 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

Worksheet E--Revised line 19 for the sequestration adjustment instructions in accordance with §3709 of the CARES Act, updated with §102 of the Consolidated Appropriations Act, 2021, signed into law on December 27, 2020, temporarily suspending the 2 percent payment adjustment currently applied to all Medicare services. The suspension is effective from May 1, 2020, through March 31, 2021.

Worksheet F-1--Added line 31.50 for the provider to report COVID-19 Public Health Emergency (PHE) funding in accordance with COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, Section V, Cost Reporting, question 2 (see the FAQs at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf).

The link to this Transmittal R9P233I

Medicare
Provider Reimbursement Manual
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 33, Form CMS-216-94

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

Transmittal 9 **Date: April 30, 2021**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3302.1 - 3302.3 (Cont.)	33-5.2 - 33-6 (2 pp.)	33-5.2 - 33-6 (2 pp.)
3312 - 3316	33-21 - 33-22 (2 pp.)	33-21 - 33-22 (2 pp.)
3390 (Cont.) - 3390 (Cont.)	33-303 - 33-304 (2 pp.)	33-303 - 33-304 (2 pp.)
3395 (Cont.) - 3395 (Cont.)	33-505 - 33-506 (2 pp.)	33-505 - 33-506 (2 pp.)
	33-513 - 33-514 (2 pp.)	33-513 - 33-514 (2 pp.)
	33-527 - 33-532 (6 pp.)	33-527 - 33-532 (6 pp.)

NEW MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Ending on or After December 31, 2020.

This transmittal clarifies and makes corrections to Chapter 33, Organ Procurement Organizations (OPOs) and independent Histocompatibility Laboratories (Labs) Cost Report, Form CMS-216-94, effective for cost reporting periods ending on or after December 31, 2020.

Revisions include:

Worksheet S, Part II:

- Assigned line numbers to existing data fields in order to capture information in the electronic cost report (ECR) file.

Worksheet D:

- Revised the sequestration adjustment instructions in accordance with §3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, updated with §102 of the Consolidated Appropriations Act, 2021, signed into law on December 27, 2020 temporarily suspending the 2 percent payment adjustment currently applied to all Medicare services. The suspension is effective from May 1, 2020 through March 31, 2021.

Edits

- Added edits: 1100S, 1105S, 1110S, 1120S, 1130S, 1140S, 2200S.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after December 31, 2020.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged.

Pub. 15-2-33

The link to this Transmittal R4P243I

Medicare
Provider Reimbursement Manual -
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 43, Form CMS-1984-14

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

Transmittal 4 **Date: ~~February~~ April 30, 2021**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents	43-1 - 43-2 (2 pp.)	43-1 - 43-2 (2 p.)
4300 - 4301	43-3 - 43-4 (2 pp.)	43-3 - 43-4 (2 pp.)
4306 - 4307.3 (Cont.)	43-7 - 43-12 (6 pp.)	43-7 - 43-12 (6 pp.)
4310 (Cont.) - 4310 (Cont.)	43-19 - 43-24 (6 pp.)	43-19 - 43-24 (6 pp.)
4318 (Cont.) - 4320	43-29 - 43-32 (4 pp.)	43-29 - 43-32 (4 pp.)
4350 (Cont.) - 4350 (Cont.)	43-39 - 43-40 (2 pp.)	43-39 - 43-40 (2 pp.)
4352.2 - 4352.2	43-43 - 43-44 (2 pp.)	43-43 - 43-44 (2 pp.)
4390 - 4390 (Cont.)	43-101 - 43-102 (2 pp.)	43-101 - 43-102 (2 pp.)
	43-105 - 43-106 (2 pp.)	43-105 - 43-106 (2 pp.)
	43-109 - 43-112 (4 pp.)	43-109 - 43-112 (4 pp.)
	43-125 - 43-126 (2 pp.)	43-125 - 43-126 (2 pp.)
4395 - 4395 (Cont.)	43-201 - 43-204 (4 pp.)	43-201 - 43-204 (4 pp.)
	43-213 - 43-216 (4 pp.)	43-213 - 43-216 (4 pp.)
	43-219 - 43-220 (2 pp.)	43-219 - 43-220 (2 pp.)
	43-223 - 43-226 (4 pp.)	43-223 - 43-226 (4 pp.)
	43-231 - 43-242 (12 pp.)	43-231 - 43-242 (12 pp.)

NEW REVISED MATERIAL--EFFECTIVE DATE: Hospice Cost Report changes effective for cost reporting periods ending on or after December 31, 2020.

This transmittal updates Chapter 43, Hospice Cost Report, (Form CMS-1984-14) to revise and modify the forms and instructions as follows:

- Worksheet S, Part II - assigned line numbers to existing lines to facilitate capturing information in the electronic cost report (ECR)
- Worksheet A - shaded line 25, column 1
- Worksheet A-3 - shaded line 25, column 1
- Worksheet A-4 - shaded line 25, column 1
- Modified description for edits 1020, 1030, 1035, 1036, 1040, 1045
- Revised edits 1200S, 1050A

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: The electronic reporting specifications are effective for cost reporting periods ending on or after December 31, 2020.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged.

Pub. 15-2-43

The link to this Transmittal R2P247I

Medicare
Provider Reimbursement Manual -
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 47, Form CMS-1728-20

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

Transmittal 2 **Date: April 30, 2021**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4709 (Cont.) - 4710	47-29 - 47-32 (4 pp.)	47-29 - 47-32 (4 pp.)
4713 (Cont.) - 4715.1	47-41 - 47-50 (10 pp.)	47-41 - 47-50 (10 pp.)
4717 (Cont.) - 4717 (Cont.)	47-53 - 47-54 (2 pp.)	47-53 - 47-54 (2 pp.)
4723 - 4724 (Cont.)	47-69 - 47-72 (4 pp.)	47-69 - 47-72 (4 pp.)
4790 (Cont.) - 4790 (Cont.)	47-307 - 47-308 (2 pp.)	47-307 - 47-308 (2 pp.)
	47-315 - 47-316 (2 pp.)	47-315 - 47-316 (2 pp.)
	47-327 - 47-328 (2 pp.)	47-327 - 47-328 (2 pp.)
	47-331 - 47-334 (4 pp.)	47-331 - 47-334 (4 pp.)
	47-337 - 47-338 (2 pp.)	47-337 - 47-338 (2 pp.)
	47-343 - 47-344 (2 pp.)	47-343 - 47-344 (2 pp.)
	47-347 - 47-358 (12 pp.)	47-347 - 47-358 (12 pp.)
4795 (Cont.) - 4795 (Cont.)	47-519 - 47-522 (4 pp.)	47-519 - 47-522 (4 pp.)
	47-535 - 47-536 (2 pp.)	47-535 - 47-536 (2 pp.)

NEW COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: Cost reporting periods beginning on or after January 1, 2020, and ending on or after December 31, 2020.

This transmittal updates Chapter 47, Home Health Agency Cost Report, Form CMS-1728-20, to update the forms and clarify the instructions.

Revisions include:

Worksheet A
- Updated instructions for lines 26 and 27.

Worksheet B
- Corrected instructions for A&G costs related to contracted services that should be excluded from the total cost statistic on Worksheet B-1, column 6.

Worksheet C, Part I
- Corrected instructions for reporting Medicare visits on column 5.

Worksheet D, Part I
- Corrected instructions for nominal charge providers.

Pub. 15-2-47

The link to this Transmittal R19P232I

Medicare
Provider Reimbursement Manual -
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 32, Form CMS-1728-94

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

Transmittal 19 **Date: April 30, 2021**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3200 - 3200 (Cont.)	32-5 - 32-6 (2 pp.)	32-5 - 32-6 (2 pp.)
3206 (Cont.) - 3207 (Cont.)	32-17 - 32-20 (4 pp.)	32-17 - 32-20 (4 pp.)
3215.3 (Cont.) - 3215.4	32-34.1 - 32-34.2 (2 pp.)	32-34.1 - 32-34.2 (2 pp.)
3216.1 - 3216.1 (Cont.)	32-35 - 32-36 (2 pp.)	32-35 - 32-36 (2 pp.)
3218 - 3219	32-41 - 32-42 (2 pp.)	32-41 - 32-42 (2 pp.)
3233 - 3235.1	32-65 - 32-68 (4 pp.)	32-65 - 32-68 (4 pp.)
3290 (Cont.) - 3290 (Cont.)	32-325 - 32-326 (2 pp.)	32-325 - 32-326 (2 pp.)
	32-347 - 32-348 (2 pp.)	32-347 - 32-348 (2 pp.)
	32-351 - 32-354 (4 pp.)	32-351 - 32-354 (4 pp.)
3295 (Cont.) - 3295 (Cont.)	32-503 - 32-504 (2 pp.)	32-503 - 32-504 (2 pp.)
	32-523 - 32-524 (2 pp.)	32-523 - 32-524 (2 pp.)
	32-530.5 - 32-530.6 (2 pp.)	32-530.5 - 32-530.6 (2 pp.)
	32-539 - 32-540.2 (4 pp.)	32-539 - 32-540.2 (4 pp.)

NEW COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: Cost reporting periods ending prior to December 31, 2020.

This transmittal updates Chapter 32, Home Health Agency Cost Report, Form CMS-1728-94 to sunset the forms and update and clarify the instructions.

Revisions include:

Worksheet A
- Updated instructions for Line 13 and 13.20.

Worksheet C, Part III
- Updated instructions for Line 16 and 16.20.

Worksheet D, Part I
- Updated instructions for Line 1 and 4.01.

Worksheet F-1
- Added line 31.50 for the provider to report COVID-19 Public Health Emergency (PHE) funding in accordance with COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, V. Cost Reporting, question 2; https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

Worksheet S-4
- Updated instructions for Rural Health Clinics.

Pub. 15-2-32

The link to this Transmittal R4P244I

Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 44, Form CMS-224-14

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

Transmittal 4

Date: ~~March~~ April 30, 2021~~2021~~

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents	44-1 - 44-2 (2 pp.)	44-1 - 44-2 (2 pp.)
4400 4400.1	44-3 - 44-4 (2 pp.)	44-3 - 44-4 (2 pp.)
4404 - 4404.2	44-7 - 44-8 (2 pp.)	44-7 - 44-8 (2 pp.)
4408 (Cont.) - 4408 (Cont.)	44-25 - 44-30 (6 pp.)	44-29 - 44-30 (6 pp.)
4414 - 4416 (Cont.)	44-37 - 44-42 (6 pp.)	44-37 - 44-42 (6 pp.)
4490 (Cont.) - 4490 (Cont.)	44-103 - 44-104 (2 pp.)	44-103 - 44-104 (2 pp.)
	44-109 - 44-110 (2 pp.)	44-109 - 44-110 (2 pp.)
	44-115 - 44-118 (4 pp.)	44-115 - 44-118 (4 pp.)
4495 (Cont.) - 4495 (Cont.)	44-203 - 44-206 (4 pp.)	44-203 - 44-206 (4 pp.)
	44-209 - 44-212 (4 pp.)	44-209 - 44-212 (4 pp.)
	44-225 - 44-228 (4 pp.)	44-225 - 44-228 (4 pp.)
	44-233 - 44-234 (2 pp,)	44-233 - 44-234 (2 pp.)
	44-237 - 44-238 (2 pp.)	44-237 - 44-238 (2 pp)
	44-241 - 44-244 (4 pp.)	44-241 - 44-244 (4 pp.)

NEW MATERIAL--EFFECTIVE DATE: Cost Reporting Periods ending on or after March 31, 2021.

This transmittal updates Chapter 44, Federally Qualified Health Center (FQHC) Cost Report, Form CMS-224-14, by revising existing edits, creating a new edit, updating references, and clarifying instructions.

Revisions include:

- Table of Contents
  Section 4413: Revised title.

- Section 4404 - Worksheet S:
  Part II: Assigned line numbers to existing data fields in order to capture information in the electronic cost report (ECR) file.

Pub. 15-2-44

The link to this Transmittal R2P246I

Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 46, Form CMS-222-17

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

Transmittal 2 **Date: April 30, 2021**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents	46-1 - 46-2 (2 pp.)	46-1 - 46-2 (2 pp.)
4600 - 4604.2	46-3 - 46-10 (8 pp.)	46-3 - 46-10 (8 pp.)
4607 (Cont.) - 4607 (Cont.)	46-25 - 46-26 (2 pp.)	46-25 - 46-26 (2 pp.)
4612 - 4614	46-33 - 46-38 (6 pp.)	46-33 - 46-38 (6 pp.)
4690 - 4690 (Cont.)	46-303 - 46-304 (2 pp.)	46-303 - 46-304 (2 pp.)
4690 (Cont.) - 4690 (Cont.)	46-307 - 46-308 (2 pp.)	46-307 - 46-308 (2 pp.)
	46-313 - 46-316 (4 pp.)	46-313 - 46-316 (4 pp.)
4695 (Cont.) - 4695 (Cont.)	46-503 - 46-506 (4 pp.)	46-503 - 46-506 (4 pp.)
	46-513 - 46-530 (18 pp.)	46-513 - 46-530 (18 pp.)
	46-533 - 46-540 (8 pp.)	46-533 - 46-540 (8 pp.)

NEW MATERIAL--EFFECTIVE DATE: Cost Reporting Periods Ending on or After March 31, 2021.

This transmittal revises, clarifies and makes corrections to Chapter 46, Rural Health Clinic (RHC) Cost Report, Form CMS-222-17, by revising existing edits, creating new edits, and updating references.

Revisions include:

- Worksheet S, Part I:
  - Revised the check box option to read "Electronically prepared cost report" and "Manually prepared cost report," on the worksheet and in the instructions.
- Worksheet S, Part II: Revised the certification section to assign line numbers to accommodate data input in the electronic cost report (ECR) file.
- Worksheet S-1, Part I, line 7, column 3: Eliminated the reporting requirement for the Health Resources and Services Administration (HRSA) award number and shaded the corresponding location on the worksheet.
- Worksheet A, lines 31.10 and 31.11: Subscripted line 31 to separate COVID-19 vaccines and monoclonal antibody products from influenza vaccine costs in accordance with §3713 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act for Medicare beneficiaries and Medicare Advantage (MA) enrollees.
- Worksheet B-1: Revised to include columns for COVID-19 vaccines and monoclonal antibody products for treatment of COVID-19.

Pub. 15-2-46

The link to this Transmittal R2P245l

Medicare
Provider Reimbursement Manual
Part 2, Provider Cost Reporting Forms and Instructions, Chapter 45, Form CMS-2088-17

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

Transmittal 2 **Date: April 30, 2021**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of contents	45-1 - 45-2 (2 pp.)	45-1 (1 pp.)
4500 - 4503.2	45-3 - 45-12 (10 pp.)	45-3 - 45-10 (10 pp.)
4505 (Cont.) - 4506	45-19 - 45-24 (6 pp.)	45-19 - 45-24 (6 pp.)
4508 - 4509	45-27 - 45-28 (2 pp.)	45-27 - 45-28 (2 pp.)
4510 - 4510 (Cont.)	45-31 - 45-32 (2 pp.)	
4512 - 4514	45-35 - 45-40 (6 pp.)	45-35 - 45-39 (5 pp.)
4590 - 4590 (Cont.)	45-301 - 45-314 (14 pp.) 45-317 - 45-318 (2 pp.)	45-301 - 45-314 (14 pp.) 45-317 - 45-318 (2 pp.)
4595 (Cont.) - 4595 (Cont.)	45-501 - 45-514 (14 pp.) 45-521 - 45-530 (10 pp.) 45-533 - 45-544 (12 pp.)	45-501 - 45-514 (14 pp.) 45-521 - 45-530 (10 pp.) 45-533 - 45-544 (12 pp.)

NEW COST REPORTING FORMS AND INSTRUCTIONS--EFFECTIVE DATE: Cost Reporting Periods Ending on or After December 31, 2020.

This transmittal updates Chapter 45, Community Mental Health Center Cost Report, Form CMS-2088-17, by clarifying, and correcting the existing instructions, forms, and electronic cost report (ECR) specifications.

Revisions include:

- Worksheet S, Part II:
  Assigned line numbers to existing data fields in order to capture information in the electronic cost report (ECR) file.
- Worksheet S-1, Part I, line 13:
  Clarified the instruction for column 2.
- Worksheets B:
  Updated to include line 99 for negative cost centers.
- Worksheet B-1:
  Renumerated line number 100 to line number 99 for negative cost centers.

Pub. 15-2-45

The link to this Transmittal R10772COM

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-09 Medicare Contractor Beneficiary and Provider Communications	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10772	**Date: April 29, 2021**
	Change Request 11918

Transmittal 10519, dated December 14, 2020, is being rescinded and replaced by Transmittal 10772, dated, April 29, 2021 to revise elements of the IOM. All other information remains the same.

SUBJECT: Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program

I. SUMMARY OF CHANGES: This Change Request (CR) revises Chapter 6 to update language and reporting requirements, as well as reorganize, correct spelling errors, update references, URLs and links.

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

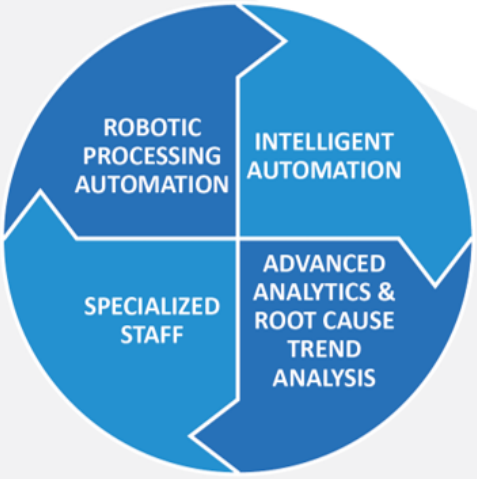
Creating results through our experience and automated processes.

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

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

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

Our Approach Uses:



HFRI Automation Process

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

Additional Benefits Include:

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

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

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

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