PARA HealthCare Analytics
HEALTHCARE FINANCIAL RESOURCES

May 6, 2020

PARA Weekly eJOURNAL

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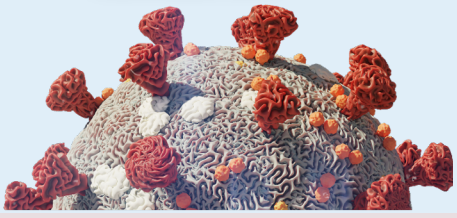


FAST LINKS

CANCER CENTER EPOETIN DENIALS

Q. On a call today reviewing our cancer center charging, it was mentioned that we should monitor any denials related to the methodology behind lab values correlation with giving epoetin and/or darbepoetin. With our center only opening a few months ago, we have not billed very many claims. But we want to make sure we don't start seeing these types of denials. Could you provide any feedback or documentation regarding what is required for the labs and drug methodology that was referenced?

A. **Answer:** The **PARA Data Editor** can provide the means to rapidly identify the denials you are looking for within electronic remittance advice files. Using our Claim/Remit tab, we can rapidly identify denials for failure to meet medical necessity (reason code CO-50) when the lab values required (hemoglobin, hematocrit) don't meet the necessity standard.

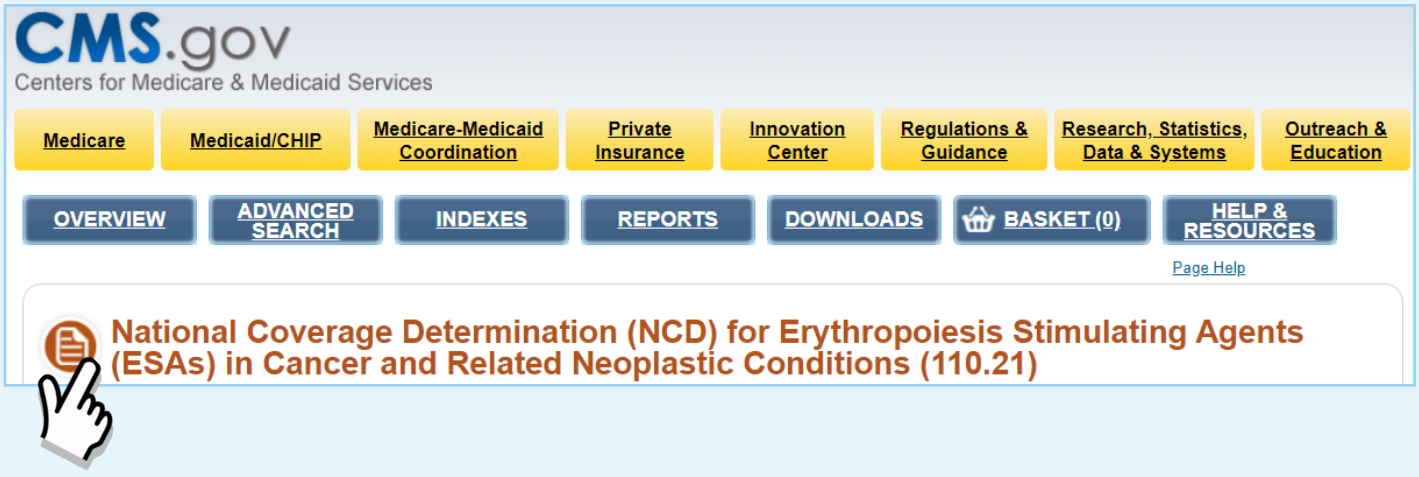
If you would like to send us remit files for the Cancer Center at some point in the future, we'd be happy to demonstrate how our system works to support you.

There are several locations in Medicare manuals that discuss the coverage requirements for Erythropoiesis Stimulating Agents like Epoetin. The bottom line is that to qualify for coverage, the patient must have one of the specified forms of cancer and the patient's hemoglobin level must be 10.0g/dL or greater, or their hematocrit level is 30.0% or greater.

For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49.

Here are several resources you may find useful: The CMS National Coverage Determination related to Epoetin is found at the link below:

https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=322



CANCER CENTER EPOETIN DENIALS

In addition, Medicare publishes a condensed NCD rule in excel; we believe the intended audience is MACs. I have attached the rule description, and here's an excerpt that discusses hemoglobin and hematocrit levels:

	B	C	
1	110.21 (CR9252, CR10318, CR10473, CR10859, CR11005)		
2	Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions		
3	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_Part2.pdf		
4	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=322&ncdver=1		
5			
6	**Rule Description Part A**	**Proposed HCPCS/CPT Part A**	
7	Effective 7/30/07, non-ESRD ESA services are **covered** for anemia secondary to myelosuppressive anti-cancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions. Non-ESRD ESA services are **non-covered** for beneficiaries with certain clinical conditions.		
8	**A/MACS & FISS**: Effective 1/1/08, shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with **modifier -EC** (ESA, anemia, non-chemo/radio) when any one of the specified non-covered diagnosis codes is present on the claim. See tab ICD Diagnosis for this list.	J0881 J0885	N
9	**FISS**: Effective 1/1/08, shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with **modifier -EB** (ESA, anemia, radio-induced) regardless of dx no discretion allowed.	J0881 J0885	N
10	**A/MAC**: Effective 1/1/08, shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with **modifier -EA** (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.	J0881 J0885	N

The Medicare Claims Processing Manual Chapter 17 - Drugs and Biologicals, Section 80.12:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf#

80.12 - Claims Processing Rules for ESAs Administered to Cancer Patients for Anti-Anemia Therapy (Rev. 3721, Issued: 02-24-17, Effective: 05-25-17, Implementation: 05-25-17)

The national coverage determination (NCD) titled, "The Use of ESAs in Cancer and Other Neoplastic Conditions" lists coverage criteria for the use of ESAs in patients who have cancer and experience anemia as a result of chemotherapy or as a result of the cancer itself. The full NCD can be viewed in Publication 100-03 of the NCD Manual, section 110.21.

Effective for claims with dates of service on and after January 1, 2008, non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EC (ESA, anemia, nonchemo/radio) shall be denied when any one of the following diagnosis codes is present on the claim:

ICD-9-CM Applicable

- any anemia in cancer or cancer treatment patients due to folate deficiency (281.2),
- B-12 deficiency (281.1, 281.3),

CANCER CENTER EPOETIN DENIALS

- iron deficiency (280.0-280.9),
- hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9-283.10, 283.19), or
- bleeding (280.0, 285.1),
- anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91); or
- erythroid cancers (207.00-207.81).

ICD-10-CM Applicable

·any anemia in cancer or cancer treatment patients due to folate deficiency - (D52.0, D52.1, D52.8, or D52.9),

•B-12 deficiency - (D51.1, D51.2, D51.3, D51.8, D51.9, or D53.1),

•iron deficiency - (D50.0, D50.1, D50.8, and D50.9),

•hemolysis - (D55.0, D55.1, D58.0, D58.9, D59.0, D59.1, D59.2, D59 4, D59.5, D59.6, D59.8, or D59.9),

•bleeding - (D50.0, D62),

•anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) - (C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.A0, C92.A1, C92.A2, C92Z0, C92Z1, or C92Z2), or

•erythroid cancers - (C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.80, C94.81, D45).

Effective for claims with dates of service on and after January 1, 2008, contractors shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EC (ESA, anemia, non-chemo/radio) for:

- •any anemia in cancer or cancer treatment patients due to bone marrow fibrosis,
- •anemia of cancer not related to cancer treatment,
- •prophylactic use to prevent chemotherapy-induced anemia,
- •prophylactic use to reduce tumor hypoxia,
- •patients with erythropoietin-type resistance due to neutralizing antibodies; and
- •anemia due to cancer treatment if patients have uncontrolled hypertension.

Effective for claims with dates of service on and after January 1, 2008, non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EB (ESA, anemia, radioinduced), shall be denied.

Effective for claims with dates of service on and after January 1, 2008, contractors shall deny non-ESRD ESA services for HCPCS J0881 or J0885 billed with modifier EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.

CANCER CENTER EPOETIN DENIALS

NOTE: ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regime.

Effective for claims with dates of service on and after January 1, 2008, Medicare contractors shall have discretion to establish local coverage policies for those indications not included in NCD 110.21.

Denials of claims for ESAs are based on reasonable and necessary determinations established by NCD 110.21. A provider may have the beneficiary sign an Advanced Beneficiary Notice, making the beneficiary liable for services not deemed reasonable and necessary and thus not covered by Medicare.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

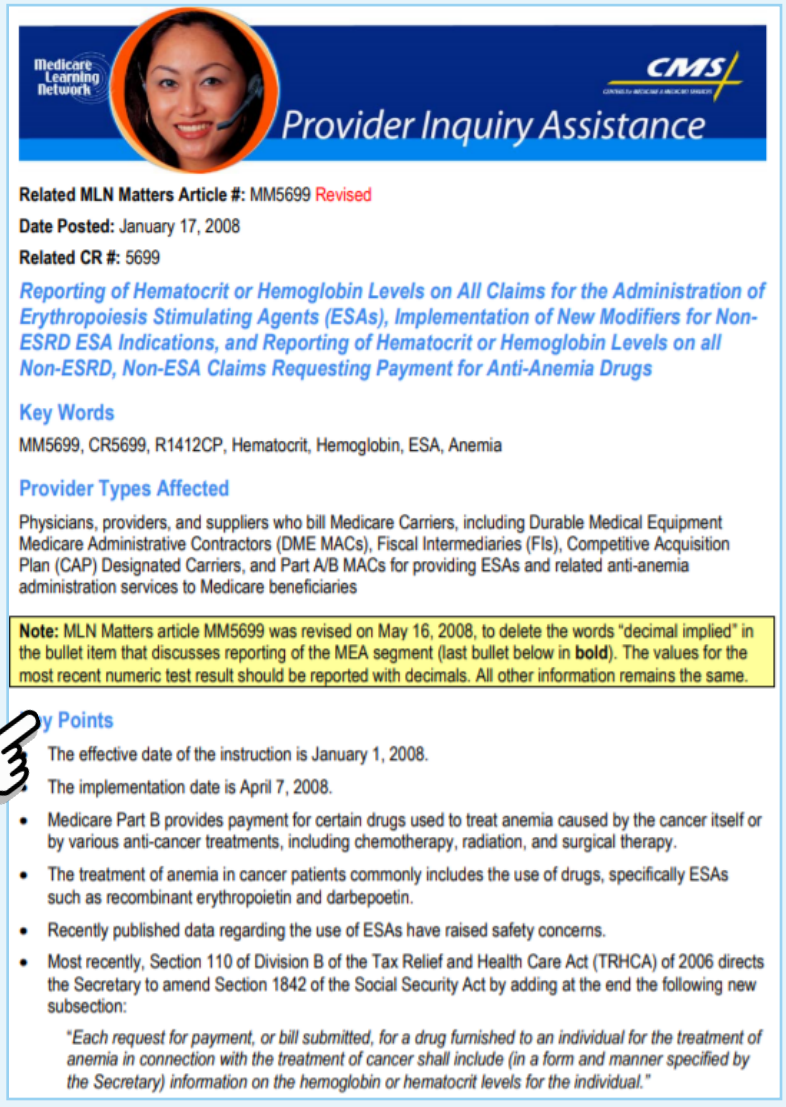
Group Code: PR or CO CARC: 50 RARC: N/A MSN: 15.20

Medicare contractors have the discretion to conduct medical review of claims and reverse the automated adjudication if the medical review results in a determination of clinical necessity.

And finally, here's a link to a 2008 MLN that explains how to report the hemoglobin and hematocrit levels in the value code section of the UB:

https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA5699.pdf

For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49."



Medicare Learning Network

CMS

Provider Inquiry Assistance

Related MLN Matters Article #: MM5699 Revised

Date Posted: January 17, 2008

Related CR #: 5699

Reporting of Hematocrit or Hemoglobin Levels on All Claims for the Administration of Erythropoiesis Stimulating Agents (ESAs), Implementation of New Modifiers for Non-ESRD ESA Indications, and Reporting of Hematocrit or Hemoglobin Levels on all Non-ESRD, Non-ESA Claims Requesting Payment for Anti-Anemia Drugs

Key Words

MM5699, CR5699, R1412CP, Hematocrit, Hemoglobin, ESA, Anemia

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare Carriers, including Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Competitive Acquisition Plan (CAP) Designated Carriers, and Part A/B MACs for providing ESAs and related anti-anemia administration services to Medicare beneficiaries

Note: MLN Matters article MM5699 was revised on May 16, 2008, to delete the words "decimal implied" in the bullet item that discusses reporting of the MEA segment (last bullet below in **bold**). The values for the most recent numeric test result should be reported with decimals. All other information remains the same.

y Points

The effective date of the instruction is January 1, 2008.

The implementation date is April 7, 2008.

- Medicare Part B provides payment for certain drugs used to treat anemia caused by the cancer itself or by various anti-cancer treatments, including chemotherapy, radiation, and surgical therapy.
- The treatment of anemia in cancer patients commonly includes the use of drugs, specifically ESAs such as recombinant erythropoietin and darbepoetin.
- Recently published data regarding the use of ESAs have raised safety concerns.
- Most recently, Section 110 of Division B of the Tax Relief and Health Care Act (TRHCA) of 2006 directs the Secretary to amend Section 1842 of the Social Security Act by adding at the end the following new subsection:

  "Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual."

ICD-10 CM DEPRESSION

Q. I had a provider who added on her assessment, " Depression, F33.1". In today's coding is this acceptable to be able to use F33.1 without stating, "Major Depression disorder, recurrent, moderate". I have been trying to find any kind of guidelines on this and she feels how she documented it should be appropriate.

A. **Answer:** It would not be appropriate to report F33.1, since the documentation does not state "recurrent or moderate". Coding Clinic 4th Qtr 2015 states, "It is not appropriate for providers to list the code number or select a code number from a list of codes in place of a written diagnostic statement. ICD-10-CM is a statistical classification, per se, it is not a diagnosis."

Therefore, the physician documentation of code F33.1 is not reportable. The documentation of "Depression" is reportable. When indexing the main term "Depression" in the alphabetic index of the ICD-10 CM code book, coders are led to F32.9, Major depressive disorder, single episode, unspecified. The inclusion terms following ICD-10 code F32.9 in the tabular index includes Depression NOS, Depressive disorder NOS and Major depression NOS. Please refer to the **PARA Data Editor** ICD-10 CM Code description.

PARA - Healthcare Financial Services

ICD10 Codes

ICD10 Code	Description
F331	Major depressive disorder, recurrent, moderate
F329	Major depressive disorder, single episode, unspecified

MLN CONNECTS

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

Thursday, April 30, 2020

News

·Infection Control Guidance to Home Health Agencies on COVID-19

·Now Available: Nursing Home Five Star Quality Rating System Updates, Nursing Home Staff Counts, and Frequently Asked Questions

·CMS Adds New COVID-19 Clinical Trials Improvement Activity to the Quality Payment Program

·Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

·Home Health Claims: Correcting Recoding Errors

Events

·COVID-19: Lessons from the Front Lines Calls — May 1 and 8

·COVID-19: Home Health and Hospice Call — May 5

·COVID-19: Office Hours Call — May 5

·COVID-19: Nursing Homes Call — May 6

MLN Matters® Articles

·July 2020 Quarterly Update to the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2020 Pricer

·Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer

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

·Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE — Revised

SECOND ROUND OF SWEEPING CHANGES SUPPORT HEALTHCARE SYSTEM

Press release

Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic

Apr 30, 2020 | Hospitals, Policy, Telehealth

At President Trump's direction, and building on its recent historic efforts to help the U.S. healthcare system manage the 2019 Novel Coronavirus (COVID-19) pandemic, the Centers for Medicare & Medicaid Services today issued another round of sweeping regulatory waivers and rule changes to deliver expanded care to the nation's seniors and provide flexibility to the healthcare system as America reopens.

These changes include making it easier for Medicare and Medicaid beneficiaries to get tested for COVID-19 and continuing CMS's efforts to further expand beneficiaries' access to telehealth services.

CMS is taking action to ensure states and localities have the flexibility they need to ramp up diagnostic testing and access to medical care, key precursors to ensuring a phased, safe, and gradual reopening of America.

These actions are informed by requests from healthcare providers as well as by the Coronavirus Aid, Relief, and Economic Security Act, or CARES Act. CMS's goals during the pandemic are to:

1. Expand the healthcare workforce by removing barriers for physicians, nurses, and other clinicians to be readily hired from the local community or other states;

2. Ensure that local hospitals and health systems have the capacity to handle COVID-19 patients through temporary expansion sites (also known as the CMS Hospital Without Walls initiative);

3. Increase access to telehealth for Medicare patients so they can get care from their physicians and other clinicians while staying safely at home;

4. Expand at-home and community-based testing to minimize transmission of COVID-19 among Medicare and Medicaid beneficiaries; and

5. Put patients over paperwork by giving providers, healthcare facilities, Medicare Advantage and Part D plans, and states temporary relief from many reporting and audit requirements so they can focus on patient care

"I'm very encouraged that the sacrifices of the American people during the pandemic are working. The war is far from over, but in various areas of the country the tide is turning in our favor," said CMS Administrator Seema Verma.

SECOND ROUND OF SWEEPING CHANGES SUPPORT HEALTHCARE SYSTEM

"Building on what was already extraordinary, unprecedented relief for the American healthcare system, CMS is seeking to capitalize on our gains by helping to safely reopen the American healthcare system in accord with President Trump's guidelines."

Made possible by President Trump's recent emergency declaration and emergency rule making, many of CMS's temporary changes will apply immediately for the duration of the Public Health Emergency declaration.They build on an unprecedented array of temporary regulatory waivers and new rules CMS announced March 30 and April 10. Providers and states do not need to apply for the blanket waivers announced today and can begin using the flexibilities immediately. CMS also is requiring nursing homes to inform residents, their families, and representatives of COVID-19 outbreaks in their facilities.

New rules to support and expand COVID-19 diagnostic testing for Medicare and Medicaid beneficiaries

"Testing is vital, and CMS's changes will make getting tested easier and more accessible for Medicare and Medicaid beneficiaries," Verma said.

Under the new waivers and rule changes, Medicare will no longer require an order from the treating physician or other practitioner for beneficiaries to get COVID-19 tests and certain laboratory tests required as part of a COVID-19 diagnosis.

During the Public Health Emergency, COVID-19 tests may be covered when ordered by any healthcare professional authorized to do so under state law. To help ensure that Medicare beneficiaries have broad access to testing related to COVID-19, a written practitioner's order is no longer required for the COVID-19 test for Medicare payment purposes.

"Testing is vital, and CMS's changes will make getting tested easier and more accessible for Medicare and Medicaid beneficiaries".

Pharmacists can work with a physician or other practitioner to provide assessment and specimen collection services, and the physician or other practitioner can bill Medicare for the services. Pharmacists also can perform certain COVID-19 tests if they are enrolled in Medicare as a laboratory, in accordance with a pharmacist's scope of practice and state law.

With these changes, beneficiaries can get tested at "parking lot" test sites operated by pharmacies and other entities consistent with state requirements. Such point-of-care sites are a key component in expanding COVID-19 testing capacity.

CMS will pay hospitals and practitioners to assess beneficiaries and collect laboratory samples for COVID-19 testing, and make separate payment when that is the only service the patient receives.

This builds on previous action to pay laboratories for technicians to collect samples for COVID-19 testing from homebound beneficiaries and those in certain non-hospital settings, and encourages broader testing by hospitals and physician practices.

To help facilitate expanded testing and reopen the country, CMS is announcing that Medicare and Medicaid are covering certain serology (antibody) tests, which may aid in determining whether a person may have developed an immune response and may not be at immediate risk for COVID-19 reinfection. Medicare and Medicaid will cover laboratory processing of certain FDA-authorized tests that beneficiaries self-collect at home.

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Increase Hospital Capacity – CMS Hospitals Without Walls

Under its Hospitals Without Walls initiative CMS has taken multiple steps to allow hospitals to provide services in other healthcare facilities and sites that aren't part of the existing hospital, and to set up temporary expansion sites to help address patient needs. Previously, hospitals were required to provide services within their existing departments.

·CMS is giving providers flexibility during the pandemic to increase the number of beds for COVID-19 patients while receiving stable, predictable Medicare payments. For example, teaching hospitals can increase the number of temporary beds without facing reduced payments for indirect medical education. In addition, inpatient psychiatric facilities and inpatient rehabilitation facilities can admit more patients to alleviate pressure on acute-care hospital bed capacity without facing reduced teaching status payments. Similarly, hospital systems that include rural health clinics can increase their bed capacity without affecting the rural health clinic's payments.

- CMS is excepting certain requirements to enable freestanding inpatient rehabilitation facilities to accept patients from acute-care hospitals experiencing a surge, even if the patients do not require rehabilitation care. This makes use of available beds in freestanding inpatient rehabilitation facilities and helps acute-care hospitals to make room for COVID-19 patients

- CMS is highlighting flexibilities that allow payment for outpatient hospital services--such as wound care, drug administration, and behavioral health services--that are delivered in temporary expansion locations, including parking lot tents, converted hotels, or patients' homes (when they're temporarily designated as part of a hospital)

- Under current law, most provider-based hospital outpatient departments that relocate off-campus are paid at lower rates under the Physician Fee Schedule, rather than the Outpatient Prospective Payment System (OPPS).

  CMS will allow certain provider-based hospital outpatient departments that relocate off-campus to obtain a temporary exception and continue to be paid under the OPPS. Importantly, hospitals may also relocate outpatient departments to more than one off-campus location, or partially relocate off-campus while still furnishing care at the original site

- Long-term acute-care hospitals can now accept any acute-care hospital patients and be paid at a higher Medicare payment rate, as mandated by the CARES Act. This will make better use during the pandemic of available beds and staffing in long-term acute-care hospitals

Healthcare Workforce Augmentation

To bolster the U.S. healthcare workforce amid the pandemic, CMS continues to remove barriers for hiring and retaining physicians, nurses, and other healthcare professionals to keep staffing levels high at hospitals, health clinics, and other facilities. CMS also is cutting red tape so that health professionals can concentrate on the highest-level work they're licensed for.

- Since beneficiaries may need in-home services during the COVID-19 pandemic, nurse practitioners, clinical nurse specialists, and physician assistants can now provide home health services, as mandated by the CARES Act.

SECOND ROUND OF SWEEPING CHANGES SUPPORT HEALTHCARE SYSTEM

These practitioners can now:

- Order home health services;
- Establish and periodically review a plan of care for home health patients; and
- Certify and re-certify that the patient is eligible for home health services. Previously, Medicare and Medicaid home health beneficiaries could only receive home health services with the certification of a physician. These changes are effective for both Medicare and Medicaid

- CMS will not reduce Medicare payments for teaching hospitals that shift their residents to other hospitals to meet COVID-related needs, or penalize hospitals without teaching programs that accept these residents. This change removes barriers so teaching hospitals can lend available medical staff support to other hospitals

CMS continues to ease Federal rules and institute new flexibilities to ensure..that care is not delayed.

- CMS is allowing physical and occupational therapists to delegate maintenance therapy services to physical and occupational therapy assistants in outpatient settings. This frees up physical and occupational therapists to perform other important services and improve beneficiary access

- Consistent with a change made for hospitals, CMS is waiving a requirement for ambulatory surgery centers to periodically reappraise medical staff privileges during the COVID-19 emergency declaration. This will allow physicians and other practitioners whose privileges are expiring to continue taking care of patients

Put Patients Over Paperwork/Decrease Administrative Burden

CMS continues to ease federal rules and institute new flexibilities to ensure that states and localities can focus on caring for patients during the pandemic and that care is not delayed due to administrative red tape.

- CMS is allowing payment for certain partial hospitalization services – that is, individual psychotherapy, patient education, and group psychotherapy – that are delivered in temporary expansion locations, including patients' homes

- CMS is temporarily allowing Community Mental Health Centers to offer partial hospitalization and other mental health services to clients in the safety of their homes. Previously, clients had to travel to a clinic to get these intensive services. Now, Community Mental Health Centers can furnish certain therapy and counseling services in a client's home to ensure access to necessary services and maintain continuity of care

- CMS will not enforce certain clinical criteria in local coverage determinations that limit access to therapeutic continuous glucose monitors for beneficiaries with diabetes. As a result, clinicians will have greater flexibility to allow more of their diabetic patients to monitor their glucose and adjust insulin doses at home

SECOND ROUND OF SWEEPING CHANGES SUPPORT HEALTHCARE SYSTEM

Further Expand Telehealth in Medicare

CMS directed a historic expansion of telehealth services so that doctors and other providers can deliver a wider range of care to Medicare beneficiaries in their homes. Beneficiaries thus don't have to travel to a healthcare facility and risk exposure to COVID-19.

- For the duration of the COVID-19 emergency, CMS is waiving limitations on the types of clinical practitioners that can furnish Medicare telehealth services. Prior to this change, only doctors, nurse practitioners, physician assistants, and certain others could deliver telehealth services. Now, other practitioners are able to provide telehealth services, including physical therapists, occupational therapists, and speech language pathologists

- Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider based department of the hospital. Examples of such services include counseling and educational service as well as therapy services. This change expands the types of healthcare providers that can provide using telehealth technology

- Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home

- CMS previously announced that Medicare would pay for certain services conducted by audio-only telephone between beneficiaries and their doctors and other clinicians. Now, CMS is broadening that list to include many behavioral health and patient education services. CMS is also increasing payments for these telephone visits to match payments for similar office and outpatient visits. This would increase payments for these services from a range of about $14-$41 to about $46-$110. The payments are retroactive to March 1, 2020

- Until now, CMS only added new services to the list of Medicare services that may be furnished via telehealth using its rulemaking process. CMS is changing its process during the emergency, and will add new telehealth services on a sub-regulatory basis, considering requests by practitioners now learning to use telehealth as broadly as possible. This will speed up the process of adding services

- As mandated by the CARES Act, CMS is paying for Medicare telehealth services provided by rural health clinics and federally qualified health clinics. Previously, these clinics could not be paid to provide telehealth expertise as "distant sites." Now, Medicare beneficiaries located in rural and other medically underserved areas will have more options to access care from their home without having to travel

- Since some Medicare beneficiaries don't have access to interactive audio-video technology that is required for Medicare telehealth services, or choose not to use it even if offered by their practitioner, CMS is waiving the video requirement for certain telephone evaluation and management services, and adding them to the list of Medicare telehealth services. As a result, Medicare beneficiaries will be able to use an audio-only telephone to get these services

SECOND ROUND OF SWEEPING CHANGES SUPPORT HEALTHCARE SYSTEM

In addition, CMS is making changes to the Medicare Shared Savings Program to give the 517 accountable care organizations (ACOs) serving more than 11 million beneficiaries greater financial stability and predictability during the COVID-19 pandemic.

ACOs are groups of doctors, hospitals, and other healthcare providers, that come together voluntarily to give coordinated high-quality care to their Medicare patients.The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds both in delivering high-quality care and spending healthcare dollars more wisely, it may share in any savings it achieves for the Medicare program.

Because the impact of the pandemic varies across the country, CMS is making adjustments to the financial methodology to account for COVID-19 costs so that ACOs will be treated equitably regardless of the extent to which their patient populations are affected by the pandemic.

CMS is also forgoing the annual application cycle for 2021 and giving ACOs whose participation is set to end this year the option to extend for another year. ACOs that are required to increase their financial risk over the course of their current agreement period in the program will have the option to maintain their current risk level for next year, instead of being advanced automatically to the next risk level.

CMS is permitting states operating a Basic Health Program to submit revised BHP Blueprints for temporary changes tied to the COVID-19 public health emergency that are not restrictive and could be effective retroactive to the first day of the COVID-19 public health emergency declaration. Previously, revised BHP Blueprints could only be submitted prospectively.

CMS sets and enforces essential quality and safety standards for the nation's healthcare system. It is also the nation's largest health insurer, serving more than 140 million Americans through Medicare, Medicaid, the Children's Health Insurance Program, and federal Health Insurance Exchanges.

For additional background information on the waivers and rule changes, go to: https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient

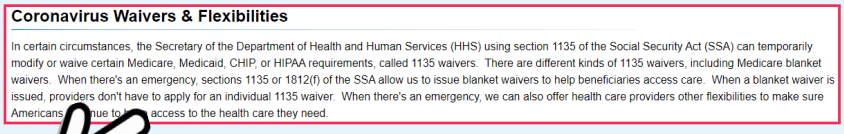
For more information on the COVID-19 waivers and guidance, and the Interim Final Rule, please go to the CMS COVID-19 flexibilities webpage:


Fact sheet

Additional Background:Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge

Mar 30, 2020 | Hospitals, Policy

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers


Coronavirus Waivers & Flexibilities

In certain circumstances, the Secretary of the Department of Health and Human Services (HHS) using section 1135 of the Social Security Act (SSA) can temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements, called 1135 waivers. There are different kinds of 1135 waivers, including Medicare blanket waivers. When there's an emergency, sections 1135 or 1812(f) of the SSA allow us to issue blanket waivers to help beneficiaries access care. When a blanket waiver is issued, providers don't have to apply for an individual 1135 waiver. When there's an emergency, we can also offer health care providers other flexibilities to make sure Americans [illegible] access to the health care they need.

These actions, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts.

To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov.

For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

PARA'S PRICE TRANSPARENCY TOOL ADVANTAGES

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

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

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

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

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

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

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

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

See A Demo By Clicking Here

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

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

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

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

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

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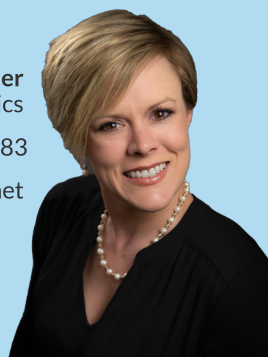

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New Guidance For FQHCs And RHCs

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

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

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

Article Release Date: April 17, 2020 | Effective Date: N/A

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

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

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

BACKGROUND

New Payment for Telehealth Services

On March 27, 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was signed into law. Section 3704 of the CARES Act authorizes RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the COVID-19 PHE. Medicare telehealth services generally require an interactive audio and video telecommunications system that permits real-time communication between the practitioner and the patient. RHCs and FQHCs with this capability can immediately provide and be paid for telehealth services to patients covered by Medicare for the duration of the COVID-19 PHE.

Distant site telehealth services can be furnished by any health care practitioner working for the RHC or the FQHC within their scope of practice. Practitioners can furnish distant site telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS). A list of these is available at

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New Guidance For FQHCs And RHCs

https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip.

The statutory language authorizing RHCs and FQHCs as distant site telehealth providers requires that CMS develop payment rates for these services that are similar to the national average payment rates for comparable telehealth services under the PFS. Payment to RHCs and FQHCs for distant site telehealth services is set at $92, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS.

For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, RHCs and FQHCs must put Modifier "95" (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) on the claim. RHCs will be paid at their all-inclusive rate (AIR), and FQHCs will be paid based on the FQHC Prospective Payment System (PPS) rate. **These claims will be automatically reprocessed in July when the Medicare claims processing system is updated with the new payment rate. RHCs and FQHCs do not need to resubmit these claims for the payment adjustment.**

For telehealth distant site services furnished between July 1, 2020, and the end of the COVID-19 PHE, RHCs and FQHCs will use an RHC/FQHC specific G code, G2025, to identify services that were furnished via telehealth. RHC and FQHC claims with the new G code will be paid at the $92 rate. Only distant site telehealth services furnished during the COVID-19 PHE are authorized for payment to RHCs and FQHCs. If the COVID-PHE is in effect after December 31, 2020, this rate will be updated based on the 2021 PFS average payment rate for these services, weighted by volume for those services reported under the PFS.

Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR or the FQHC PPS rates but must be reported on the appropriate cost report form. RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled "Cost Other Than RHC Services." FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of the Worksheet A, in the section titled "Other FQHC Services".

Since telehealth distant site services are not paid under the RHC AIR or the FQHC PPS, the Medicare Advantage wrap-around payment does not apply to these services. Wrap-around payment for distant site telehealth services will be adjusted by the MA plans.

During the COVID-19 PHE, CMS will pay all of the reasonable costs for any service related to COVID-19 testing, including applicable telehealth services, for services furnished beginning on March 1, 2020. For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries. For services in which the coinsurance is waived, RHCs and FQHCs must put the "CS" modifier on the service line. **RHC and FQHC claims with the "CS" modifier will be paid with the coinsurance applied, and the Medicare Administrative Contractor (MAC) will automatically reprocess these claims beginning on July 1. Coinsurance should not be collected from beneficiaries if the coinsurance is waived.**

Expansion of Virtual Communication Services

Payment for virtual communication services now include online digital evaluation and management services. Online digital evaluation and management services are non-face-to-face,

New Guidance For FQHCs And RHCs

patient-initiated, digital communications using a secure patient portal. The online digital evaluation and management codes that are billable during the COVID-19 PHE are:

- CPT code 99421 (5-10 minutes over a 7-day period)
- CPT code 99422 (11-20 minutes over a 7-day period)
- CPT code 99423 (21 minutes or more over a 7-day period)

To receive payment for the new online digital evaluation and management (CPT codes 99421, 99433, and 99423) or virtual communication services (HCPCS codes G2012 and G2010), RHCs and FQHCs must submit an RHC or FQHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. For claims submitted with HCPCS code G0071 on or after March 1, 2020, and for the duration of the COVID-19 PHE, payment for HCPCS code G0071 is set at the average of the national non-facility PFS payment rates for these 5 codes. Claims submitted with G0071 on or after March 1 and for the duration of the PHE will be paid at the new rate of $24.76, instead of the CY 2020 rate of $13.53. **MACs will automatically reprocess any claims with G0071 for services furnished on or after March 1 that were paid before the claims processing system was updated.**

Revision of Home Health Agency Shortage Requirement for Visiting Nursing Services

RHCs and FQHCs can bill for visiting nursing services furnished by an RN or LPN to homebound individuals under a written plan of treatment in areas with a shortage of home health agencies (HHAs). Effective March 1, 2020, and for the duration of the COVID-19 PHE, the area typically served by the RHC, and the area included in the FQHC service area plan, is determined to have a shortage of HHAs, and no request for this determination is required. RHCs and FQHCs must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.

Consent for Care Management and Virtual Communication Services

Beneficiary consent is required for all services, including non-face-to-face services. During the PHE, beneficiary consent may be obtained at the same time the services are initially furnished. For RHCs and FQHCs, this means that beneficiary consent can be obtained by someone working under general supervision of the RHC or FQHC practitioner, and direct supervision is not required to obtain consent. In general, beneficiary consent to receive these services may be obtained by auxiliary personnel under general supervision of the billing practitioner; and the person obtaining consent can be an employee, independent contractor, or leased employee of the billing practitioner. For RHCs and FQHCs, beneficiary consent to receive these services may be obtained by auxiliary personnel under general supervision of the RHC or FQHC practitioner; and the person obtaining consent can be an employee, independent contractor, or leased employee of the RHC or FQHC practitioner (see: https://www.cms.gov/files/document/covid-final-ifc.pdf).

Accelerated/Advance Payments

In order to increase cash flow to providers and suppliers impacted by COVID-19, CMS has expanded our current Accelerated and Advance Payment Program. An accelerated/advance payment is a payment intended to provide necessary funds when there is a disruption in claims

New Guidance For FQHCs And RHCs

submission and/or claims processing. CMS is authorized to provide accelerated or advance payments during the period of the PHE to any RHC or FQHC who submits a request to their MAC and meets the required qualifications. Each MAC will work to review requests and issue payments within seven calendar days of receiving the request. Traditionally repayment of these advance/accelerated payments begins at 90 days; however, for the purposes of the COVID-19 pandemic, CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. Providers can get more information on this process at https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.

ADDITIONAL INFORMATION

View the complete list of coronavirus waivers.

Review information on the current emergencies webpage at https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page.

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

DOCUMENT HISTORY

Date of Change	Description
April 17, 2020	Initial article released.

PARA
HealthCare Analytics

HEALTHCARE
FINANCIAL
RESOURCES

COVID-19

april, twenty-twenty

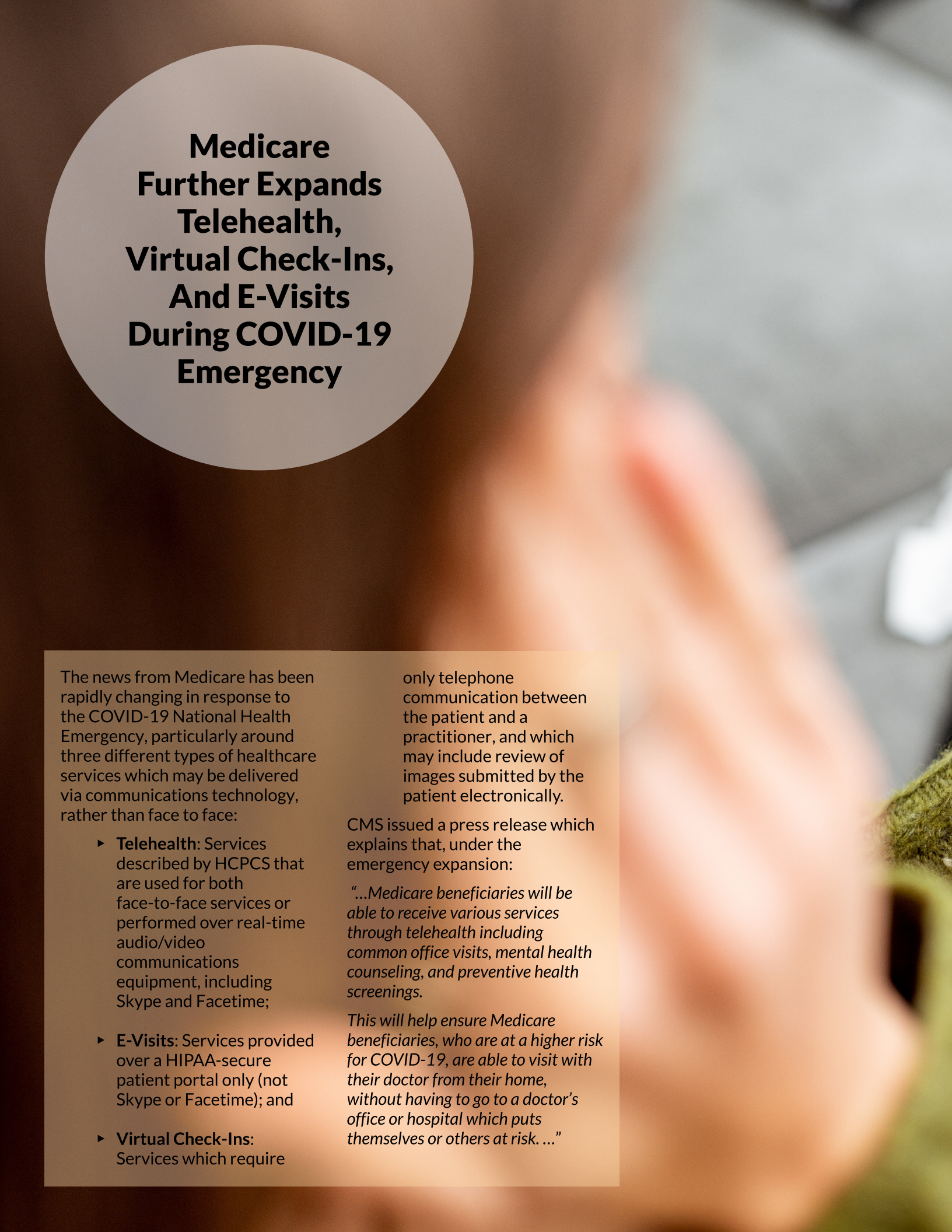
Special
publication

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

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

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

Medicare Further Expands Telehealth, Virtual Check-Ins, And E-Visits During COVID-19 Emergency



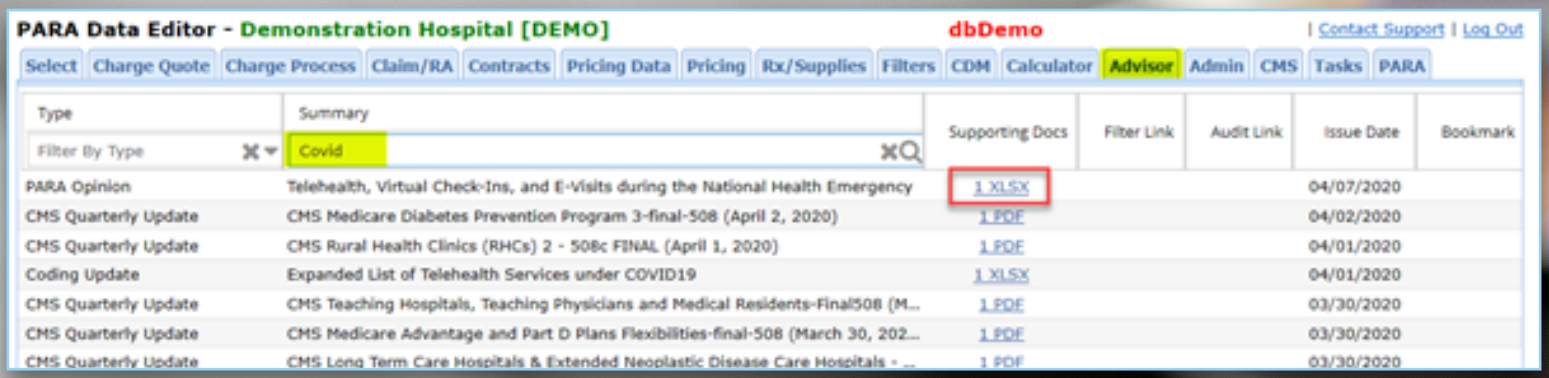
The news from Medicare has been rapidly changing in response to the COVID-19 National Health Emergency, particularly around three different types of healthcare services which may be delivered via communications technology, rather than face to face:

- **Telehealth**: Services described by HCPCS that are used for both face-to-face services or performed over real-time audio/video communications equipment, including Skype and Facetime;
- **E-Visits**: Services provided over a HIPAA-secure patient portal only (not Skype or Facetime); and
- **Virtual Check-Ins**: Services which require only telephone communication between the patient and a practitioner, and which may include review of images submitted by the patient electronically.

CMS issued a press release which explains that, under the emergency expansion:

"…Medicare beneficiaries will be able to receive various services through telehealth including common office visits, mental health counseling, and preventive health screenings.

This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home, without having to go to a doctor's office or hospital which puts themselves or others at risk. …"



A Medicare provider-specific fact sheet on new waivers and flexibilities is available at

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

Among the provisions, great interest has been expressed regarding the following new flexibilities: 1) An expansion of Medicare **telehealth** services billed on professional fee claims allows more services to be rendered by more providers to both **new and established patients** under the "shelter at home" restrictions.Under the original telehealth program, Medicare had a limited list of services that were reimbursed in only rural locations at an approved "originating site" using a HIPAA-secure audio-visual system.

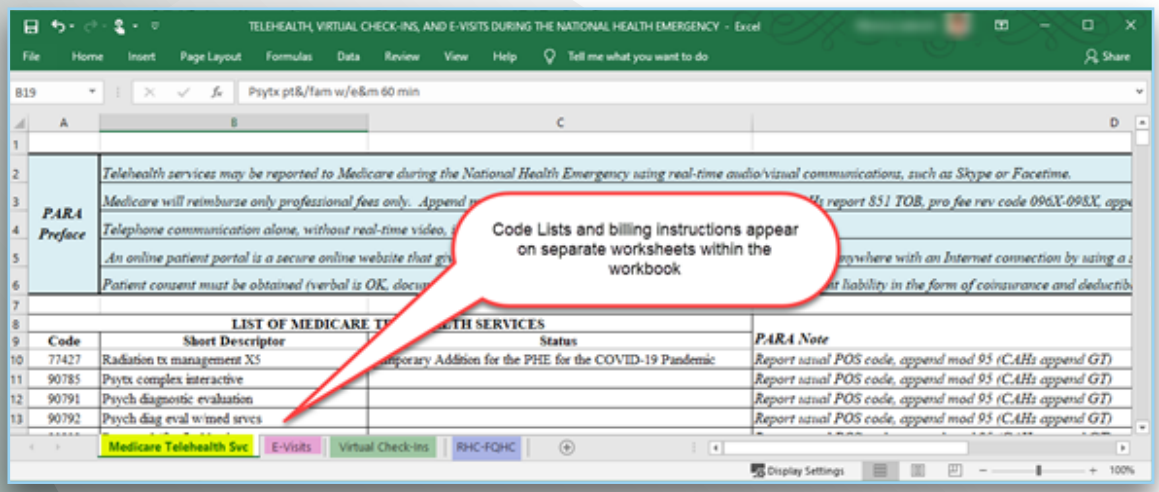
However, Medicare recently expanded the list of billable services, the acceptable technology, the types of professionals that may be reimbursed, and removed the rural geographic limitation.

Among the added services are:

- Emergency Department Visits, Levels 1-5 (CPT® codes 99281-99285); Critical Care Services (CPT® codes 99291-99292)

- Initial and Subsequent Observation and Observation Discharge Day Management (CPT® codes 99217- 99220; CPT® codes 99224- 99226; CPT® codes 99234- 99236)Home Visits, New and Established Patient, All levels (CPT® codes 99341- 99345; CPT® codes 99347- 99350)

Telehealth, continued



- Therapy Services, Physical and Occupational Therapy, by (CPT® codes 97161- 97168; CPT® codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)

- Psychological and Neuropsychological Testing (CPT® codes 96130- 96133; CPT® codes 96136- 96139)

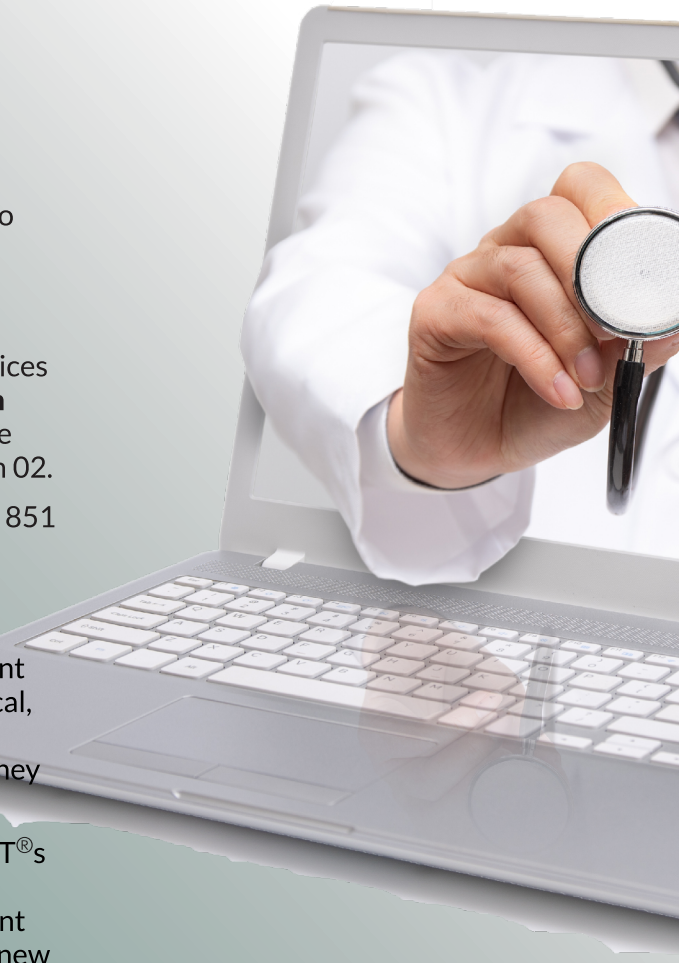
- Office visits: 99201-99215

The acceptable technology for telehealth services now includes real-time audio/visual communications, such as Facetime or Skype, so that the patient may remain at home (HIPAA regulations have been temporarily relaxed so long as providers are rendering care in good faith).

Modifier 95: During the National Health Emergency, telehealth services should be reported on professional fee claims (CMS1500/837p) **with modifier 95 appended** to the telehealth HCPCS. The Place of Service code should report the provider's typical place of service, rather than 02.

Method II Critical Access Hospitals report telehealth services on the 851 type of bill under professional fee revenue codes 096X-098X; CAHs must append modifier GT to indicate that the service was rendered remotely.

2)**Virtual Check-Ins and E-Visits**: CMS also expanded reimbursement to allow more provider types, including LCSWs, Psychologists, physical, occupational, and speech therapists in private practice, to report professional services that are **not** considered "telehealth", because they may rely on phone communication alone, without real-time video.



- **Virtual Check-Ins**: (G2010, G2012, and new coverage for CPT®s 98966-98968 and 99441-99443); which uses phone communication service alone, or with video and/or images sent to the provider by the patient; these codes are valid for both new or established patients during the emergency;

- **E-Visits**: (99421 – 99423 for physicians, and G2061-G2063 for mid-level practitioners) communications with patients conducted over a provider's online patient portal. (E-Visits must use a HIPAA-secure patient portal; providers who wish to deliver E/M

services over technology such as Facetime or Skype should use the telehealth visit codes, not the e-visit codes.)

Virtual check-ins and E-Visits may be reported on professional fee claim forms without a modifier, and under the provider's usual Place of Service code (i.e. 11 or 22). The HCPCS descriptions for these services are exclusive to remote services, and therefore do not require modifier 95. (Similarly, CAHs need not append modifier GT to the virtual check-in or E-visit codes.)

The telehealth/E-Visit/Virtual Check-In expansion is limited to professional fees reported on a CMS1500/837p claim form by an enrolled physician or non-physician practitioner.

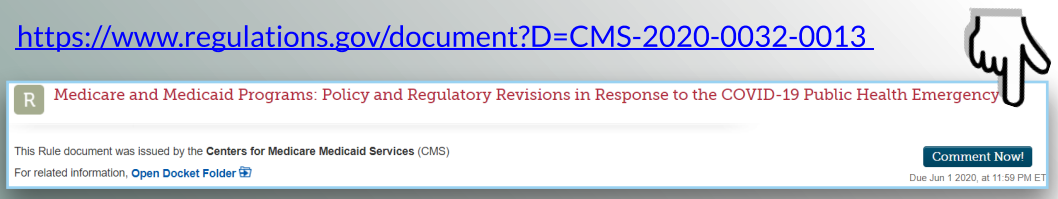
It does not extend to facility fee claims at this time.This has frustrated facility-based physical, occupational, and speech therapists because Medicare will permit telehealth service for independent PT/OT/ST practitioners, but there is currently no provision for reporting telehealth therapy on a facility fee claim. Hospital based therapists must enroll with Medicare as an individual billing practitioner, and bill using the professional fee claim form, in order to be reimbursed for therapy services delivered by telehealth.

CMS has offered expedited enrollment for billing professionals to help meet the needs of the COVID-19 emergency; a fact sheet on provider enrollment relief is available at:

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf.

CMS may make further changes in response to comments. The regulations which implement the expansion are found in the CMS "Interim Final Rule"; CMS will accept public comments until June 1, 2020.

https://www.regulations.gov/document?D=CMS-2020-0032-0013



CMS addresses HIPAA concerns within its "Telemedicine Provider Fact Sheet", which specifically mentions the use of telecommunications that will serve the patient in the home, such as FaceTime or Skype:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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

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

Telehealth, continued

According to an FAQ published by Medicare, telehealth, e-visits, and virtual check-in services are reimbursed for professional fees only – they are not payable to facilities:

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

13. Q: Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?

A: Billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report their telehealth services under CAH Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014. But the professional services can be paid for.

No modifier CR on telehealth claims: Some providers have inquired about modifiers that were historically required when responding to regional disasters, such as Hurricane Katrina, which required modifier CR (Catastrophe Related) on professional fees.

CMS does not require modifier CR on telehealth claims during the COVID National Health Emergency, however, claims for other professional fees that are rendered under the "waiver" authority may require modifier CR.

Modifier CS may be appropriate for some visits: Professionals, outpatient facilities, and RHC/FQHC providers are instructed to append **modifier CS** to the line item(s) which were related to the physician's order to test for COVID-19.

If a claim was submitted before this announcement was known, the provider may submit a corrected claim with modifier CS. The official description of modifier CS is a holdover from a past disaster --"Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the gulf of Mexico, including but not limited to subsequent clean-up activities."

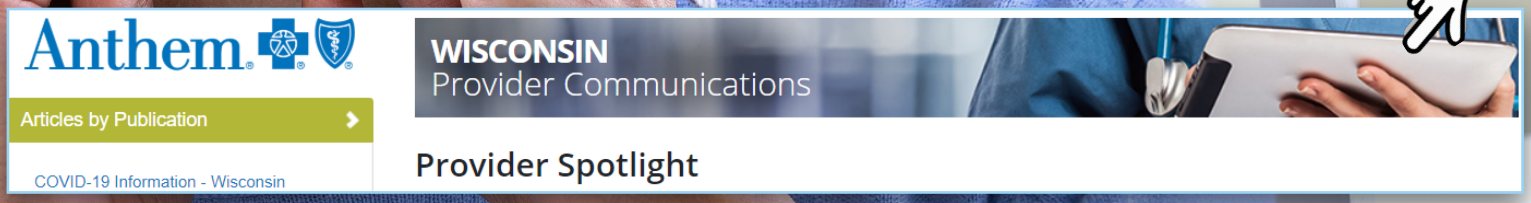
In late March, Medicare announced that professional fees for telemedicine may report the usual POS code used by the billing provider, as long as modifier 95 is appended to the HCPCS on the professional fee claim.

The POS 02 (telehealth) will still be honored, but will result in payment under the Medicare physician fee schedule at the lower "facility" rate. Practitioners who would normally report POS 11 (Office) on claims to Medicare will receive higher reimbursement if they continue to use that POS code and append modifier 95.

Method II Critical Access Hospitals must report modifier GT on telehealth professional fees submitted to Medicare on a UB04/837i outpatient claim.

Private payers may require either modifier GT or 95 – as found in the following excerpt from Anthem of Wisconsin's provider bulletin:

https://providernews.anthem.com/wisconsin



Telehealth, continued

What codes would be appropriate to consider for a telehealth visit with a patient who wants to receive health guidance related to COVID-19?

Based on standard coding guidelines from the AMA and HCPCS, Anthem would recognize telehealth modifiers 95 or GT that are appended with office visit codes 99201-99215, for reimbursement as a telehealth service. Anthem also recognizes, but does not require Place of Service (POS) code "02" for reporting telehealth services.

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

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

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

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

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

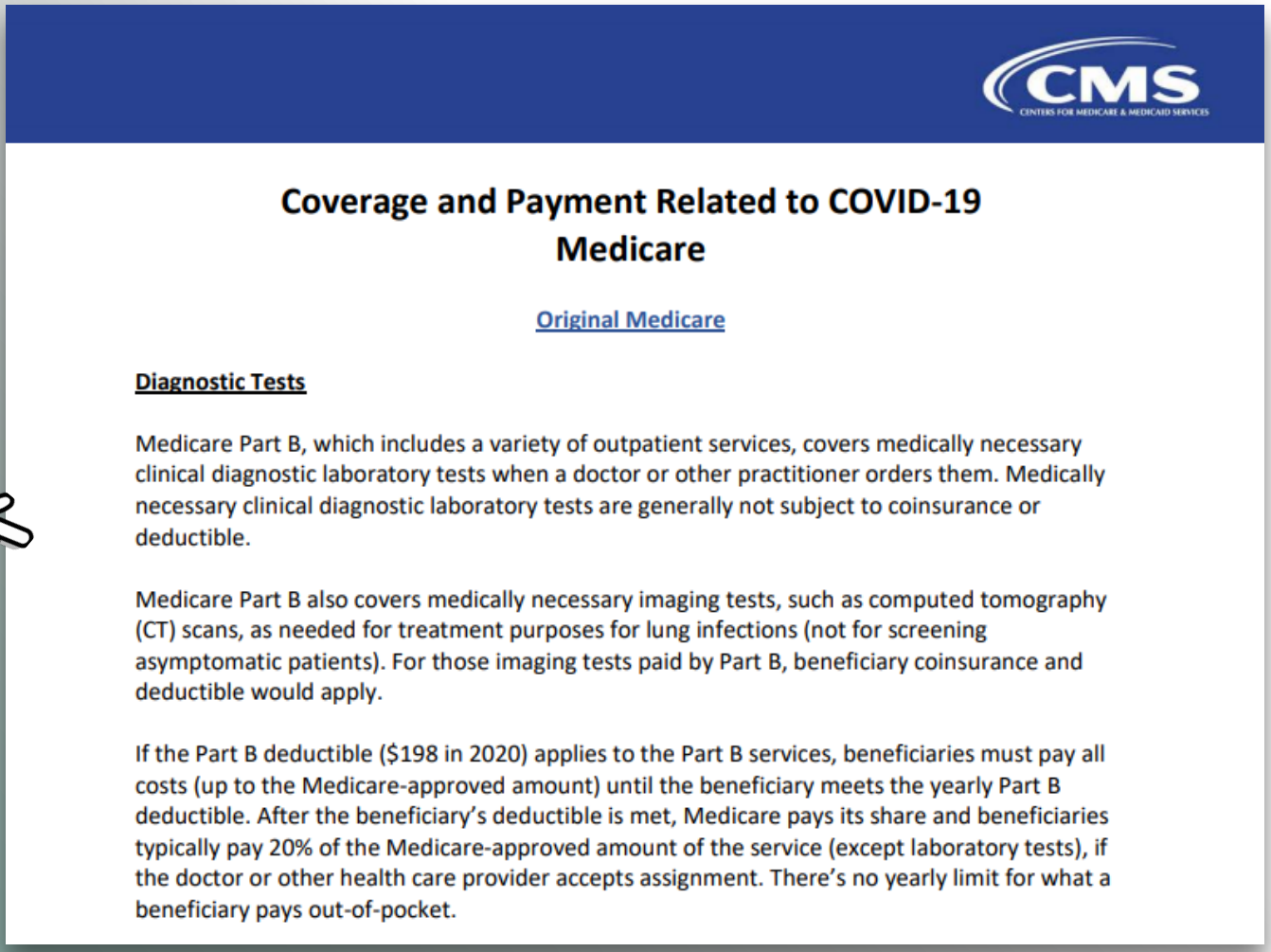
https://apps.para-hcfs.com/para/Documents/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

COVID-19 Emergency Declaration
Health Care Providers Fact Sheet

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

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



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Coverage and Payment Related to COVID-19 Medicare

Original Medicare

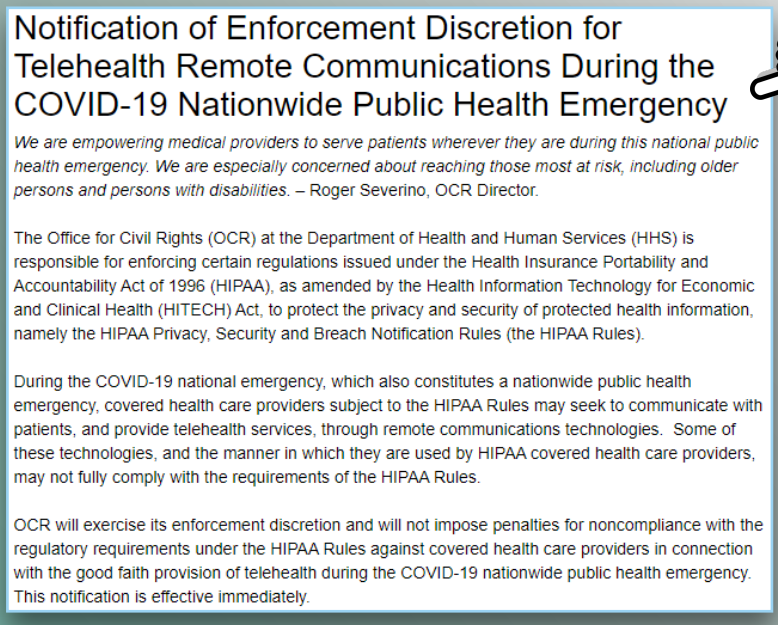
Diagnostic Tests

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

Medicare Part B also covers medically necessary imaging tests, such as computed tomography (CT) scans, as needed for treatment purposes for lung infections (not for screening asymptomatic patients). For those imaging tests paid by Part B, beneficiary coinsurance and deductible would apply.

If the Part B deductible ($198 in 2020) applies to the Part B services, beneficiaries must pay all costs (up to the Medicare-approved amount) until the beneficiary meets the yearly Part B deductible. After the beneficiary's deductible is met, Medicare pays its share and beneficiaries typically pay 20% of the Medicare-approved amount of the service (except laboratory tests), if the doctor or other health care provider accepts assignment. There's no yearly limit for what a beneficiary pays out-of-pocket.

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



Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency

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

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

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

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

COVID-19 Lab Testing And Specimen Collection Update

Special Update

During the last week of March, 2020, CMS announced the creation of two new Level II HCPCS to reimburse the collection of specimens for COVID-19 testing.The CMS announcement indicates the new codes are reimbursed to only independent laboratories (which we interpret to include outpatient hospital labs) effective for services billed with a line item date of service on or after March 1, 2020.

G2023- Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source

G2024- Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

While a hospital laboratory is deemed to be an independent laboratory, the CMS "Interim Final Rule" specifies that G2023 and G2024 are limited to collection performed in the patient home, or for a non-hospital inpatient (such as a patient in a Skilled Nursing Facility.) Here's the section from the rule, page 94:

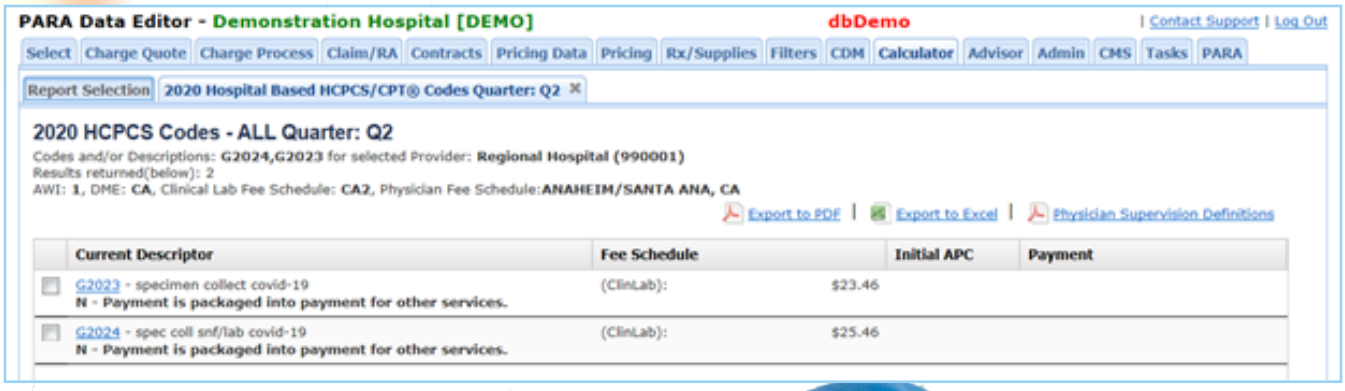
https://www.cms.gov/files/document/covid-final-ifc.pdf

"Under this policy, the nominal specimen collection fee for COVID-19 testing for homebound and non-hospital inpatients generally will be $23.46 and for individuals in a SNF or individuals whose samples will be collected by laboratory on behalf of an HHA will be $25.46.

Medicare-enrolled independent laboratories can bill Medicare for the specimen collection fee using one of two new HCPCS codes for specimen collection for COVID-19 testing and bill for the travel allowance with the current HCPCS codes set forth in section 60.2 of the Medicare Claims Processing Manual (P9603 and P9604). Our policy will also incorporate the clarification in the definition of homebound as discussed in section II.F. of this IFC, relating to the clarification of homebound status under the Medicare home health benefit."

Therefore, Medicare will **not** reimburse hospitals for swab collection performed for outpatients or inpatients which are not in a SNF or at home (homebound)--at least not at this time.

During the CMS "Office Hours" teleconference on 4/13/2020, Medicare representatives acknowledged that hospitals cannot report



G2023 for outpatients that are not homebound or in a SNF. They hinted that CMS will evaluate whether facilities should be reimbursed for G2023 (or another code) in the future. While appears to be under consideration but at this time, G2023 is not reimbursed for outpatient specimen collection that is not in a SNF or the patient's home.

If the laboratory sends a tech to collect a COVID-19 test specimen for an individual in a SNF or to a homebound patient on behalf of a Home Health Agency, Medicare will also reimburse mileage in keeping with the established HCPCS for that purpose, P9603 or P9604.

P9603- Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated miles actually traveled

P9604- Travel allowance one way in connection with medically necessary laboratory specimen collection drawn from home bound or nursing home bound patient; prorated trip charge

(For further information on calculating and billing the travel allowance, see **PARA's** Q&A document at

https://apps.para-hcfs.com/para/Documents/Q&A%20-%20Lab%20Travel%20Allowance.pdf.

CMS has indicated that due to the COVID-19 emergency, the definition of "homebound" includes those patients for whom travel is "medically contra-indicated" as determined by a physician. The discussion of the definition of "homebound" is on page 100 of the Interim Final Rule at the link on the following page.

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

"In defining an individual who is homebound for purposes of the specimen collection fee and the travel allowance under section 1833(h)(3) of the Act, the manual refers to Chapters 7 and 15 of Pub. 100-02, the Medicare Benefit Policy Manual.

The definition of "homebound" in Chapters 7 and 15 of Pub. 100-02 originate from the statutory definition of "confined to the home" (that is, "homebound") under sections 1814(a) and 1835(a) of the Act.

As discussed in section II.F. of this IFC, relating to the clarification of homebound status under the Medicare home health benefit patients are considered "confined to the home" (that is, "homebound") if it is medically contraindicated for the patient to leave the home.

When it is medically contraindicated

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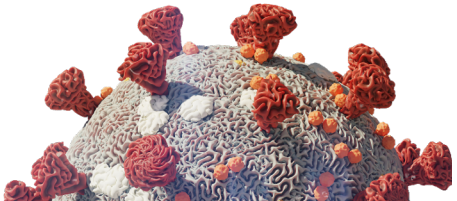


COVID-19 Lab Testing, con't.

for a patient to leave the home, there exists a normal inability for an individual to leave home and leaving home safely would require a considerable and taxing effort.

"As an example for the PHE for COVID-19 pandemic, this would apply for those patients:

(1) where a physician has determined that it is medically contraindicated for a beneficiary toleave the home because he or she has a confirmed or suspected diagnosis of COVID-19; or

(2) where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19.

A patient who is exercising "self-quarantine" for his or her own safety, would not be considered "homebound" unless it is also medically contraindicated for the patient to leave the home. Determinations of whether the patient is homebound must be based on an assessment of each beneficiary's individual condition.For the PHE for the COVID-19 pandemic, the CDC is currently advising that older adults and individuals with serious underlying health conditions stay home (CDC's guidance is interim and is expected to continue to be updated as warranted).

As such, during the PHE for the COVID-19 pandemic, we expect that many Medicare beneficiaries could be considered "homebound". In light of this clarification regarding the definition of homebound, we are noting this clarification pertains to the specimen collection fee and travel allowance in the PHE for COVID-19 pandemic testing for homebound patients; that is, a patient is considered homebound for purposes of the fees under sections1833(h)(3) and 1834A(b)(5) of the Act if it is medically contraindicated for the patient to leave home."

As previously reported by **PARA**, the COVID-19 tests are reported by laboratories with the following codes:

87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
U0001	CDC 2019 Novel Coronavirus (2019-NCOV) real-time RT-PCR diagnostic panel
U0002	U0002 - 2019-NCOV Coronavirus, SARS-COV-2/2019-NCOV (COVID-19), any technique, multiple types or subtypes (includes all targets), Non-CDC

Payment rates are approximately $36 for U0001, and $51 for U0002, until Medicare establishes national payment rates using its annual process later this year.

As of this update, the payment rates for 87635 has not been announced.

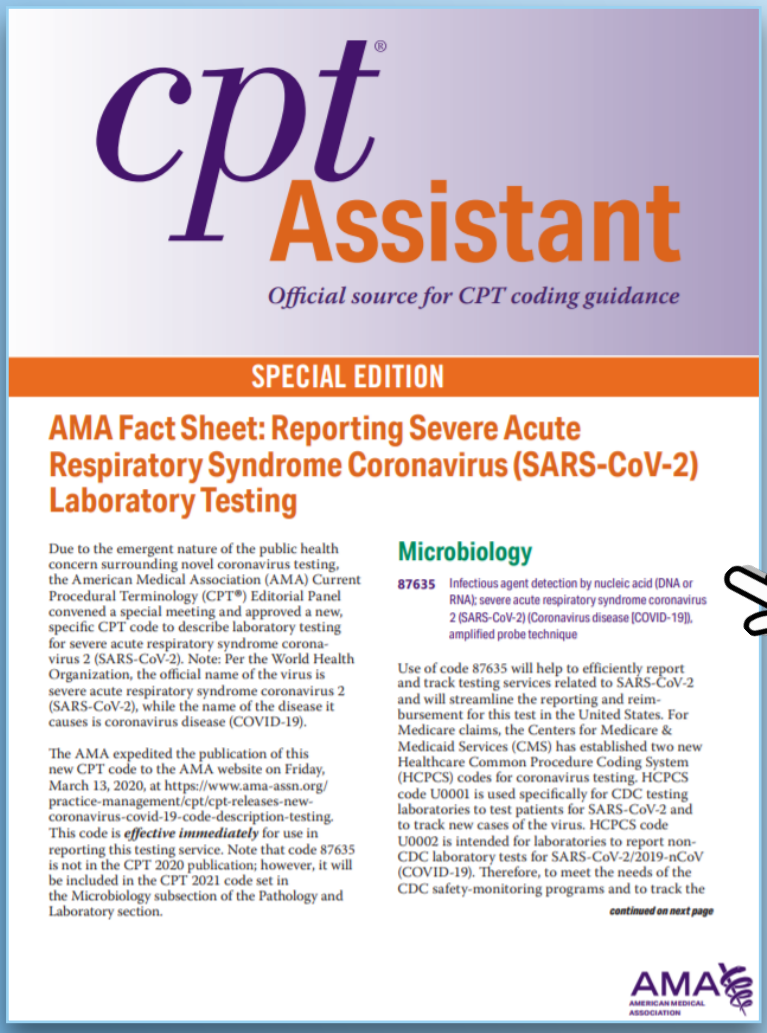
The rates for U0001 and U0002 were published at the following link:

MAC Jurisdiction (J)	MAC States/Territories	U0001 Test Price	U0002 Test Price
J6 – National Government Services (NGS)	Illinois, Minnesota, Wisconsin	$35.91	$51.31
JK – National Government Services (NGS)	Connecticut, New York, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	$35.91	$51.31
JH – Novitas Solutions	Arkansas, Colorado, New Mexico, Oklahoma, Texas Louisiana, Mississippi	$35.92	$51.33

https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf

The American Medical Association has published a special edition of CPT® Assistant regarding new CPT® 87635 at the following link:

https://www.ama-assn.org/system/files/2020-03/cpt-assistant-guide-coronavirus.pdf



cpt® Assistant

Official source for CPT coding guidance

SPECIAL EDITION

AMA Fact Sheet: Reporting Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV-2) Laboratory Testing

Due to the emergent nature of the public health concern surrounding novel coronavirus testing, the American Medical Association (AMA) Current Procedural Terminology (CPT®) Editorial Panel convened a special meeting and approved a new, specific CPT code to describe laboratory testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Note: Per the World Health Organization, the official name of the virus is severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), while the name of the disease it causes is coronavirus disease (COVID-19).

The AMA expedited the publication of this new CPT code to the AMA website on Friday, March 13, 2020, at https://www.ama-assn.org/practice-management/cpt/cpt-releases-new-coronavirus-covid-19-code-description-testing. This code is ***effective immediately*** for use in reporting this testing service. Note that code 87635 is not in the CPT 2020 publication; however, it will be included in the CPT 2021 code set in the Microbiology subsection of the Pathology and Laboratory section.

Microbiology

87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique

Use of code 87635 will help to efficiently report and track testing services related to SARS-CoV-2 and will streamline the reporting and reimbursement for this test in the United States. For Medicare claims, the Centers for Medicare & Medicaid Services (CMS) has established two new Healthcare Common Procedure Coding System (HCPCS) codes for coronavirus testing. HCPCS code U0001 is used specifically for CDC testing laboratories to test patients for SARS-CoV-2 and to track new cases of the virus. HCPCS code U0002 is intended for laboratories to report non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). Therefore, to meet the needs of the CDC safety-monitoring programs and to track the

continued on next page

AMA AMERICAN MEDICAL ASSOCIATION

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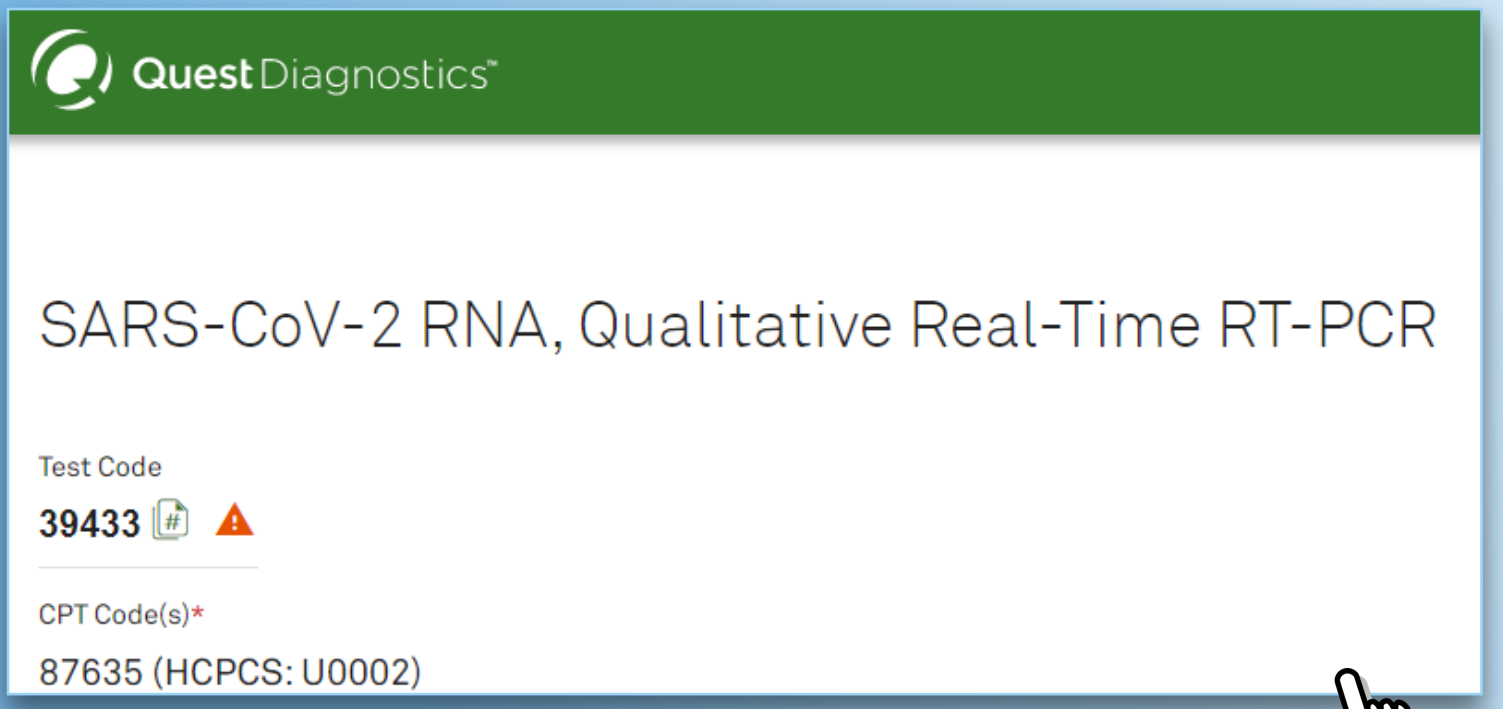
COVID-19 Lab Testing, con't.

Some large commercial laboratories appear to be opting for 87635, including LabCorp and Quest:

https://www.labcorp.com/coronavirus-disease-covid-19/health-plan-information#main

https://testdirectory.questdiagnostics.com/test/test-detail/39433/sars-cov-2-rna-qualitative-real-time-rt-pcr?q=39433&cc=MASTER



COVID-19 Resource Guide

Coronavirus

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

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

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

Get waiver & flexibility information

General information & updates:

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

Clinical & technical guidance:

For all clinicians

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

For all health care providers

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

For health care facilities

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

COVID-19 Resource Guide

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

For Labs

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

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

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

Billing And Coding Guidance:

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

For Health Care Facilities

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

COVID-19 Resource Guide

Survey And Certification Guidance:

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

Coverage Guidance:

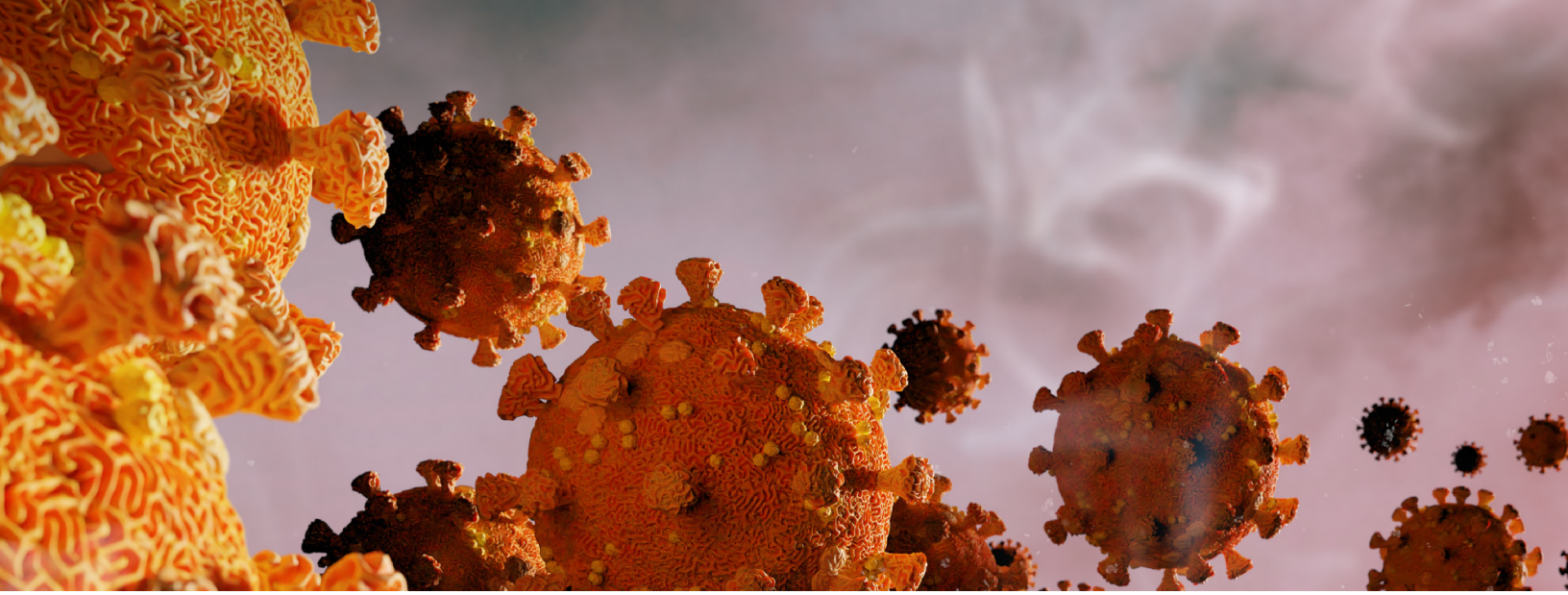
- Frequently Asked Questions to Assist Medicare Providers (PDF)UPDATED (4/11/20)
- VIDEO-MLN Medicare Coverage and Payment of Virtual Services(4/10/20)
- CMS Dear Clinician Letter (PDF)(4/6/20)
- Long-Term Care Nursing Homes Telehealth and Telemedicine Toolkit (PDF)(3/27/20)
- Fact sheet:Medicare Coverage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

Provider Enrollment Guidance:

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

Medicaid & CHIP Guidance:

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



On April 7, 2020 CMS announced that retroactive to March 18, 2020, Medicare will waive the Medicare cost-sharing liability for medical services (e.g. office visits, emergency department visits).

This can lead to a provider's decision to order a COVID-19 lab test (U0001, U0002, or 87635.)

This means that Medicare beneficiaries will not be liable for coinsurance or deductible for those services that led to the decision to test, and Medicare will pay the full allowable amount.

Additionally, the CARES Act temporarily suspended the 2% sequestration discount from May 1, 2020 through December 31, 2020.

Professionals, outpatient facilities, and RHC/FQHC providers are instructed to append **modifier CS** to the line item(s) representing services that led to the physician's order to test for COVID-19.

If a claim was submitted before this announcement was known, the provider may submit a corrected claim with modifier CS – thereby relieving the patient of the coinsurance and deductible (and increasing the direct payment to the billing provider.)

The official description of modifier CS is a holdover from a past disaster – "Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the gulf of Mexico, including but not limited to subsequent clean-up activities."

A link and an excerpt from the CMS announcement appear in this article.

Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services.

These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE):

That result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test, and, are in any of the following categories of HCPCS evaluation and management codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services

Report Modifier CS For Certain COVID-19 Services

New Billing And Coding Guidance

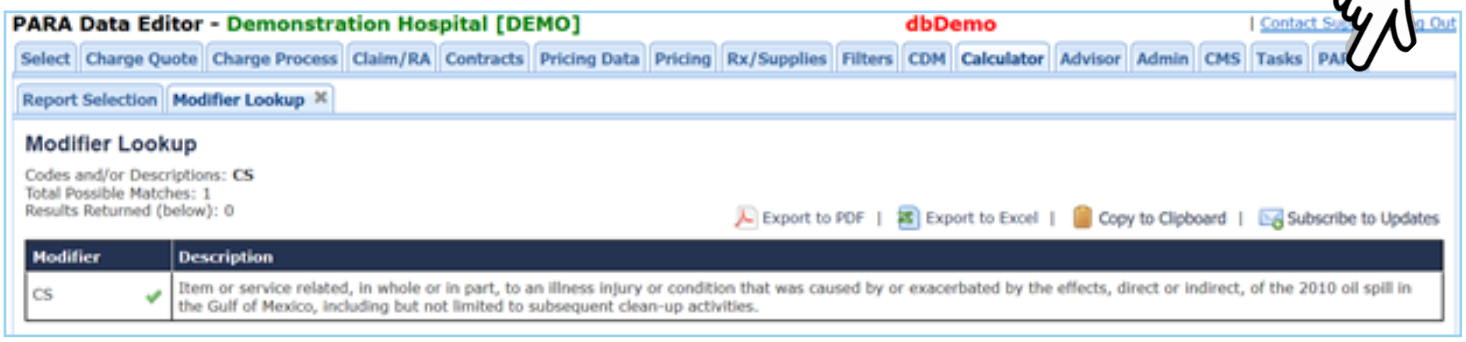
- Online digital evaluation and management services
- Cost-sharing does not apply to the above medical visit services for which payment is made to:
- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

For services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

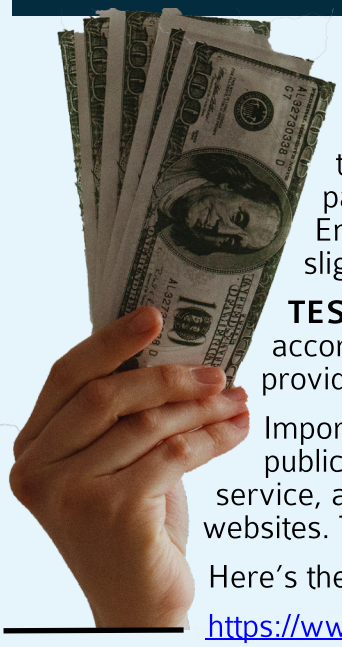
For professional claims, physicians and practitioners who did not initially submit claims with the CS modifier must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the CS modifier to get 100% payment.

For institutional claims, providers, including hospitals, CAHs, RHCs, and FQHCs, who did not initially submit claims with the CS modifier must resubmit applicable claims submitted on or after 3/18/2020, with the CS modifier to visit lines to get 100% payment.

https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se#_Toc37139913



PATIENT LIABILITY FOR COVID-19 TESTING AND RELATED SERVICES



Under the Families First Coronavirus Relief Act and the CARES Act that followed, Medicare and commercial payers are required to cover COVID-19 testing and certain related evaluation and management services in full, without patient liability (coinsurance/copay/deductible) during the National Health Emergency. The rules which govern which services are to be covered in full differ slightly for Medicare and non-Medicare payers.

TESTING: Commercial payers are required to pay for COVID-19 testing either according to their negotiated agreement with a provider, or at the "cash" rate(s) the provider publishes on its public website.

Importantly, hospitals which test for COVID-19 must display the test prices on their public website.The CARES Act stipulates what non-Medicare payers must pay for the service, and it requires that hospitals must post the price of testing on their public websites. There is a $300/day penalty for hospitals which fail to do so.

Here's the section of the CARES Act that addresses that obligation:

https://www.congress.gov/bill/116th-congress/senate-bill/3548/text

SEC. 4202. Pricing of diagnostic testing

(a) Reimbursement rates.—A group health plan or a health insurance issuer providing coverage of items and services described in section 201(a) with respect to an enrollee shall reimburse the provider of the diagnostic testing as follows:

(1) If the health plan or issuer has a negotiated rate for such service with such provider, such negotiated rate shall apply.

(2) If the health plan or issuer does not have a negotiated rate for such service with such provider, such plan or issuer shall reimburse the provider in an amount that equals the cash price for such service as listed by the provider on a public internet website.

(b) Requirement to Publicize Cash Price for Diagnostic Testing for COVID-19.—

(1) IN GENERAL.—Each provider of a diagnostic test for COVID-19 shall make public the cash price for such test on a public internet website of such provider.

(2) CIVIL MONETARY PENALTIES.—The Secretary of Health and Human Services may impose a civil monetary penalty on any provider of a diagnostic test for COVID-19 that is not in compliance with paragraph (1) and has not completed a corrective action plan to comply with the requirements of such paragraph, in an amount not to exceed $300 per day that the violation is ongoing.

Medicare is required to pay for testing under the Clinical Laboratory Fee Schedule.Since most CLFS services do not result in beneficiary liability under original Medicare, the most significant feature of the provision is that Medicare will waive the coinsurance/copay/deductible for an evaluation and management service relating to COVID-19 testing, i.e. the E/M visit during which the provider made the decision to test. For Medicare, providers are instructed to append modifier CS to the EM visit code if it relates to the decision to test for COVID-19.

Commercial payers are required to waive the patient liability for the testing and the visit, but the patient liability for the visit must be covered "to the extent" that the evaluation and management service relates to the practitioner's decision to order the test. Depending on the diagnoses and services reported for the encounter, commercial payers may or may not cover the patient liability for the evaluation visit in full.

Providers are advised to check with commercial payers for billing instructions; some payers ask providers to identify EM services that relate to COVID-19 testing with modifier CS (services related to a catastrophic event), or with modifier 32 (mandated services).

PATIENT LIABILITY FOR COVID-19 TESTING AND RELATED SERVICES

Here's the pertinent excerpt from the Code of Federal Regulations that implements the FFCRA/CARES law regarding waiving patient liability for Medicare patients:

https://uscode.house.gov/view.xhtml?req=(title:42%20section:1395l%20edition:prelim)

§1395l. Payment of benefits

(a)Amounts

...

(DD) with respect to a specified COVID–19 testing-related service described in paragraph (1) of subsection (cc) for which payment may be made under a specified outpatient payment provision described in paragraph (2) of such subsection, the amounts paid shall be 100 percent of the payment amount otherwise recognized under such respective specified outpatient payment provision for such service,;

...

(cc) Specified COVID–19 testing-related services

For purposes of subsection (a)(1)(DD):

(1) Description

(A) In general

A specified COVID–19 testing-related service described in this paragraph is a medical visit that-

(i) is in any of the categories of HCPCS evaluation and management service codes described in subparagraph (B);

(ii) is furnished during any portion of the emergency period (as defined in section 1320b–5(g)(1)(B) of this title) (beginning on or after March 18, 2020);

(iii) results in an order for or administration of a clinical diagnostic laboratory test described in section 1395w–22(a)(1)(B)(iv)(IV) of this title; and(iv) relates to the furnishing or administration of such test or to the evaluation of such individual for purposes of determining the need of such individual for such test.

(B) Categories of HCPCS codes

For purposes of subparagraph (A), the categories of HCPCS evaluation and management services codes are the following:

(i) Office and other outpatient services.

(ii) Hospital observation services.

(iii) Emergency department services.

(iv) Nursing facility services.

(v) Domiciliary, rest home, or custodial care services.

(vi) Home services.

(vii) Online digital evaluation and management services.

PATIENT LIABILITY FOR COVID-19 TESTING AND RELATED SERVICES

(2) Specified outpatient payment provision

A specified outpatient payment provision described in this paragraph is any of the following:

(A) The hospital outpatient prospective payment system under subsection (t).

(B) The physician fee schedule under section 1395w–4 of this title.

(C) The prospective payment system developed under section 1395m(o) of this title.

(D) Section 1395m(g) of this title, with respect to an outpatient critical access hospital service.

(E) The payment basis determined in regulations pursuant to subsection (a)(3) for rural health clinic services.

Commercial insurers are required to cover COVID-related testing, but not for visits that do not result in testing, and only to the extent that the visit relates to the decision to test.

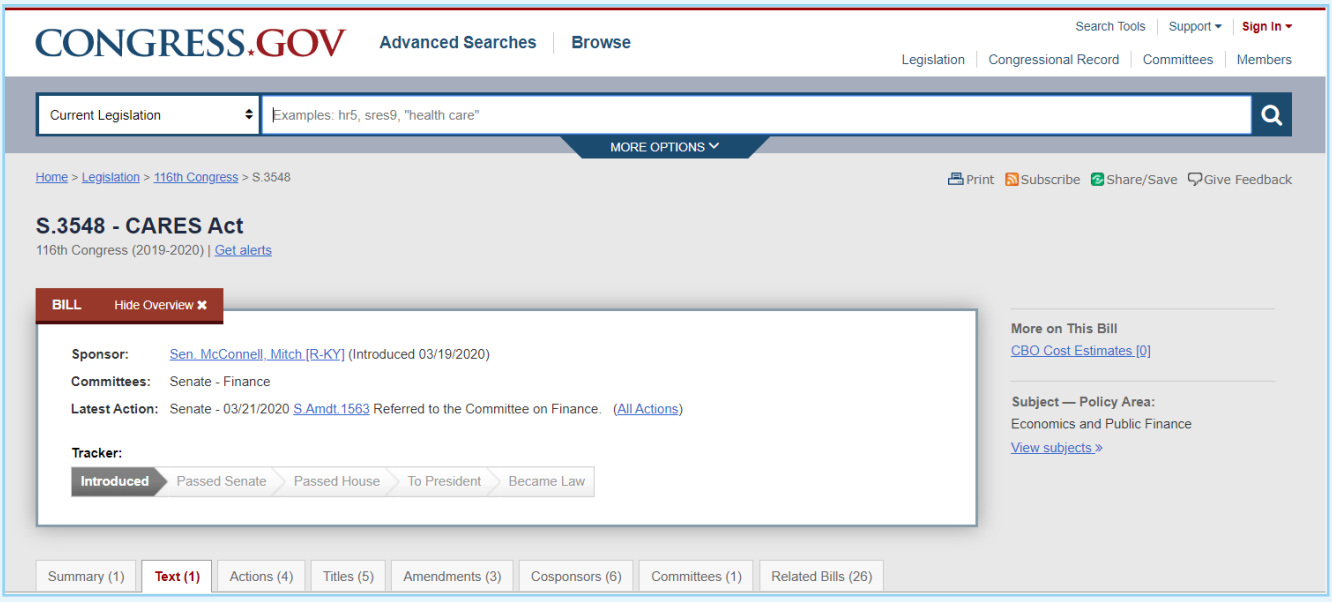
The COVID-19 Testing Mandate does not Apply to Treatment. The Act only requires that health plans cover COVID-19 testing and related health care provider visits in full, without patient cost sharing.It does not mandate that COVID-19 treatment be covered without patient liability.

However, IRS recently ruled that high deductible health plans may voluntarily cover COVID-19 testing and treatment services prior to the HDHP deductible being satisfied. Some plans are offering to cover treatment in full.

There is an important difference in the language applicable to commercial payers. They must cover, without patient liability, the visit that results in an order for COVID-19 testing, but only to the extent that the visit was for the purpose of evaluating the need for testing. We don't expect that most commercial payers will split hairs, but it is possible that payors will not cover in full a claim for an evaluation service during which the decision to test was reached, but which reports a variety of non-COVID-19 symptoms and/or services (i.e. foot care, cerumen removal, etc).

The section of the law that applies to commercial insurers is provided below:

https://www.congress.gov/bill/116th-congress/senate-bill/3548/text#toc-id39DA4007062A49C8BF5D183C3DD4C7FC



PATIENT LIABILITY FOR COVID-19 TESTING AND RELATED SERVICES

SEC. 4201. Coverage of diagnostic testing for COVID-19

(a) In general.—A group health plan and a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18011(b))) shall provide coverage, and shall not impose any cost-sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during any portion of the public health emergency declared by the Secretary of Health and Human Services pursuant to section 319 of the Public Health Service Act on January 31, 2020, with respect to COVID-19, beginning on or after the date of the enactment of this Act:

(1) An in vitro diagnostic product (as defined in section 809.3(a) of title 21, Code of Federal Regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such an in vitro diagnostic product, that—

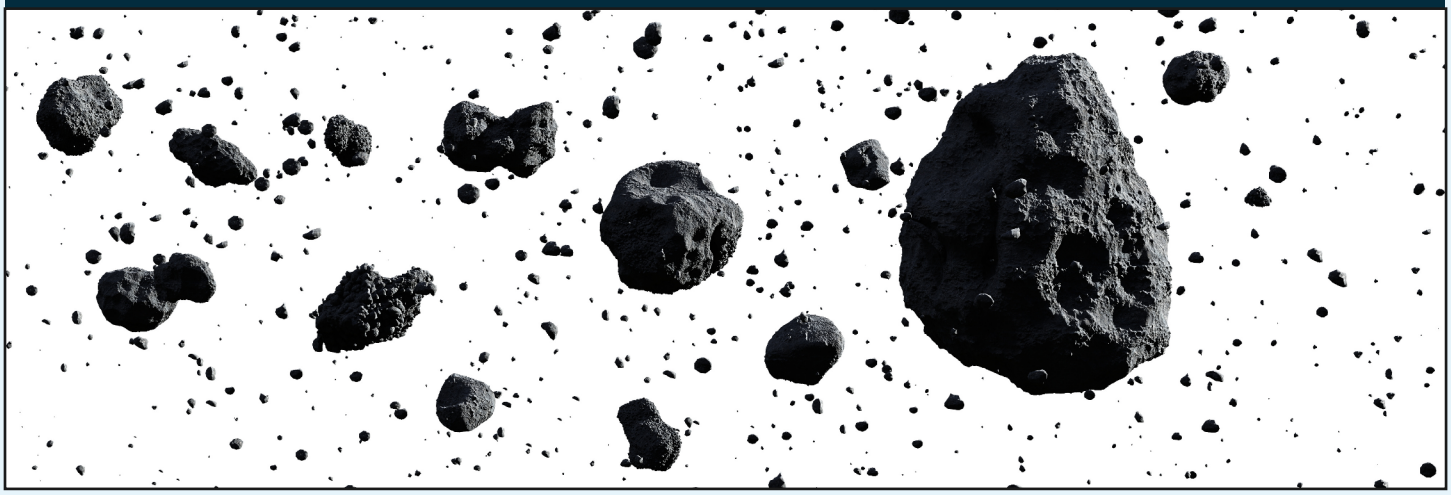
(A) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb–3);

(B) is a clinical laboratory service performed in a laboratory (including a public health laboratory) certified to conduct high-complexity testing pursuant to section 353 of the Public Health Service Act (42 U.S.C. 253a) for which the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe; or

(C) is developed in a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19.

(2) Items and services furnished to an individual during health care provider office visits, urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

COVID-19 CONDITION CODE DR, MODIFIER CR GUIDANCE



CMS guidance on the use of condition code DR (Disaster Related) on facility fee claims, and modifier CR (Catastrophe Related) on either facility fee claims or professional fee claims, has evolved over the course of the first weeks of the National Health Emergency. In the early days of the emergency, CMS indicated that neither CR nor DR were required.

However, since that time, CMS has instructed providers to report these codes when care is provided under one of the Section 1135 waivers to address the National Health Emergency. Waivers include, for example:

- Suspension of enforcement of EMTALA requirements (permitting patients seeking emergency department care to be screened at an off-site location)
- Provider Licensing and Enrollment (permitting cross-state practice and expedited enrollment)
- Suspension of Enforcement Activities related to HIPAA (for FaceTime, Skype, etc. in good faith to serve patient needs during the National Health Emergency.)
- Telehealth (expanded to non-rural areas, as well as an expanded list of service codes)
- The timeliness of physician signature requirements on orders

In an FAQ document posted on April 17, 2020, CMS provided the following guidance:

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

General Billing Requirements

1. Question: Regarding the use of the condition code "DR" and modifier "CR", should these codes be used for all billing situations relating to COVID-19 waivers?

Answer: Yes. Use of the "DR" condition code and "CR" modifier are mandatory for institutional and non-institutional providers in billing situations related to COVID-19 for any Updated: 4/17/2020 pg. 36 claim for which Medicare payment is conditioned on the presence of a "formal waiver" (as defined in the CMS Internet Only Manual, Publication 100-04, Chapter 38, § 10).

The DR condition code is used by institutional providers only, at the claim level, when all of the services/items billed on the claim are related to a COVID-19 waiver. The CR modifier is used by both institutional and non-institutional providers to identify Part B line item services/items that are related to a COVID-19 waiver.

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

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

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

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

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

COVID-19 CONDITION CODE DR, MODIFIER CR GUIDANCE

From this published FAQ, **PARA** offers the following interpretation:

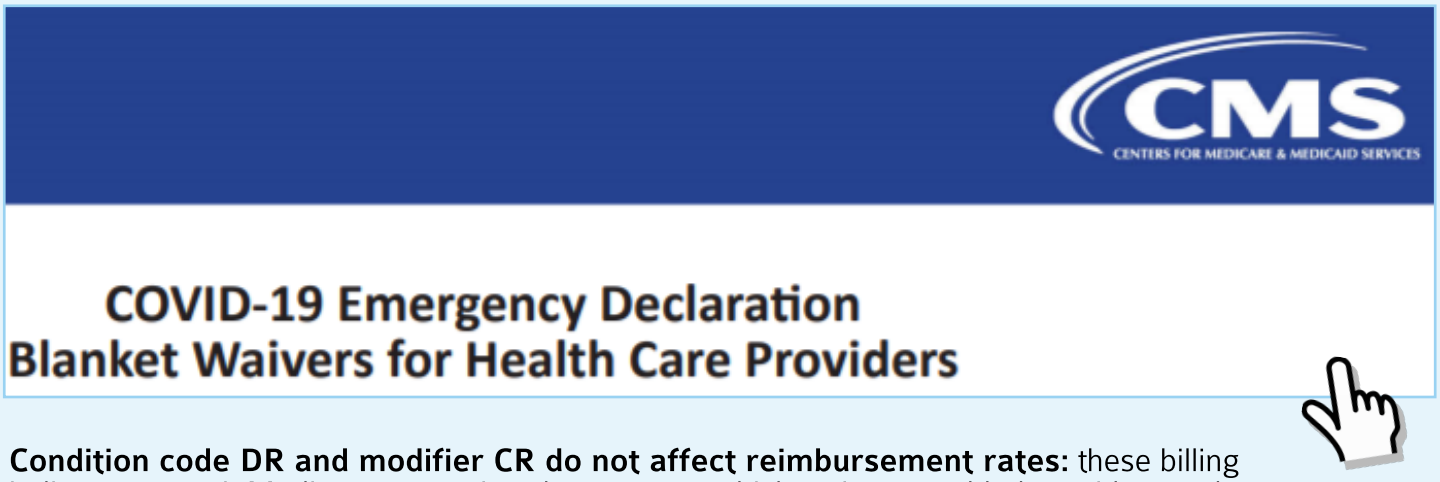
- **For facility fee claims, both inpatient and outpatient:** report condition code DR if all the services on the claim were rendered under a COVID-19 waiver; for example, if care is provided at an unusual location (e.g. a hotel used as a temporary hospital during the COVID-19 emergency)

- **For facility fee outpatient claims:** if some, but not all, services reported on a claim were rendered under a COVID-19 waiver, report modifier CR on the line items that were rendered subject to the waiver.For example, if an emergency department visit/assessment was performed in a temporary parking lot tent used for triage, report modifier CR on the code that represents that service. However, any services performed using the hospital's usual facilities do not require the CR modifier, such as imaging and lab tests that are performed within the hospital itself

- **Professional fees:** for services rendered in temporary locations, such as an extension of the emergency department in a parking lot tent or at a temporary hospital location such as a gymnasium, should report the appropriate CPT®/HCPCS with modifier CR

Additional information about the various waivers is available at the following link:

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



Condition code DR and modifier CR do not affect reimbursement rates: these billing indicators permit Medicare to monitor the extent to which waivers enabled providers and practitioners to respond to the COVID-19 emergency.

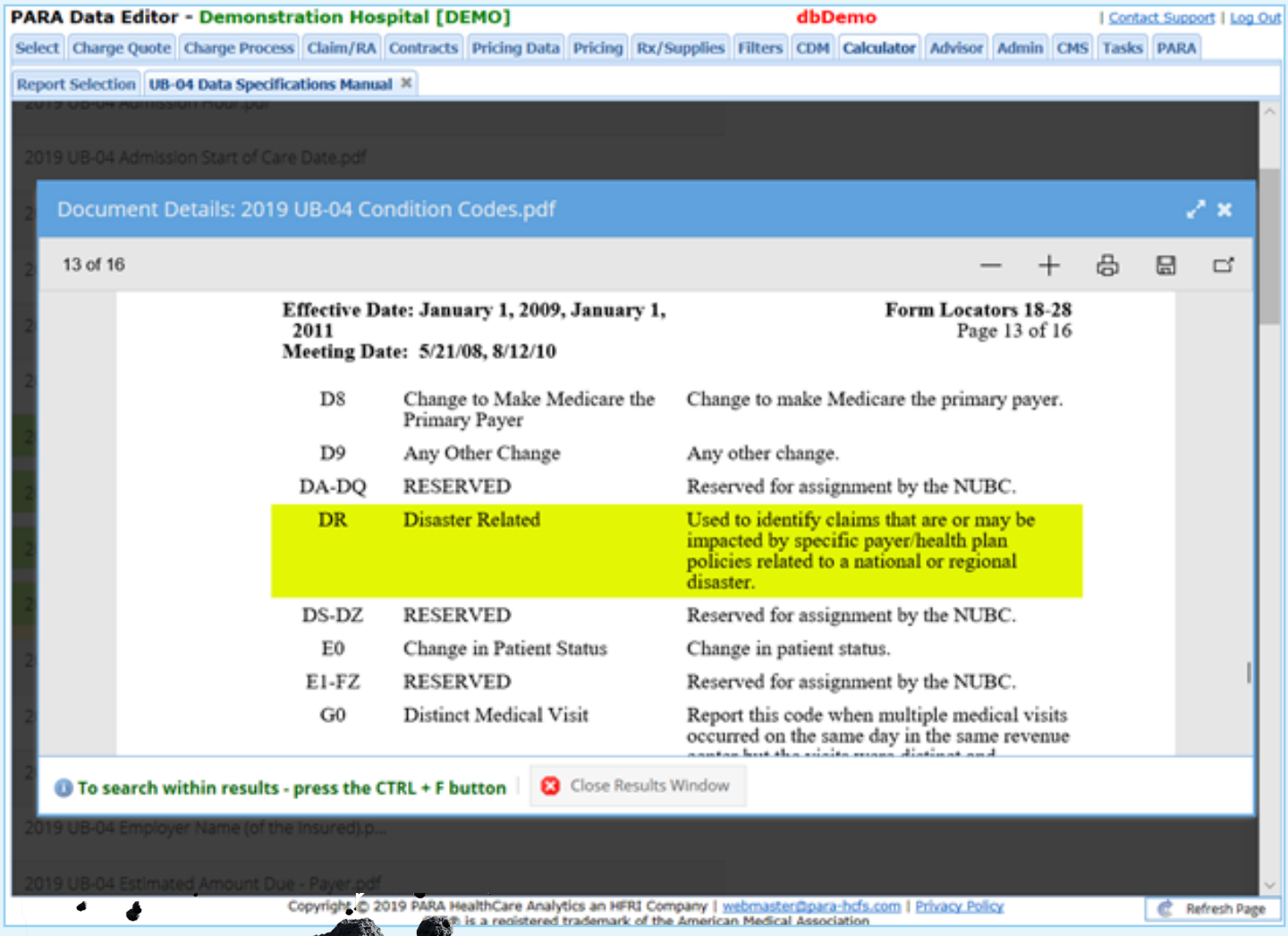
The requirement to report the DR condition code or CR modifier depends on whether the conditions of service were only permissable due to a waiver: If, for example, an acute-care facility admitted and cared for a COVID-19 patient at its usual location, with its established medical providers, from the time of admission to discharge, no condition code DR is necessary, because the care did not require a special exception from the ordinary rules governing the delivery of care.

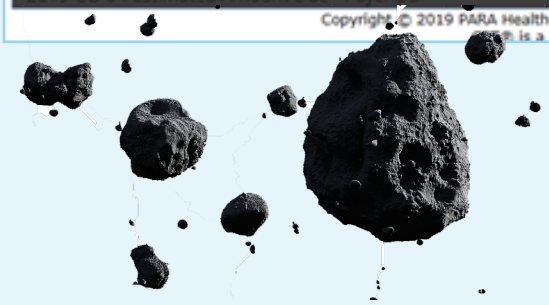
If, on the other hand, inpatient care is rendered via telehealth at an urban hospital (attending physician does not have a face-to-face encounter), the facility fee claim should report condition code DR, and the professional fee claim for the inpatient services via telehealth should report modifier CR (in addition to modifier 95 to indicate telehealth services.)

CMS announced that it will pay an increase of 20% more in DRG reimbursement for IPPS hospitals rendering COVID-19 inpatient care. That increased reimbursement is not dependent on condition code DR; claims which are eligible for increased reimbursement based on the ICD-10 codes alone.

COVID-19 CONDITION CODE DR, MODIFIER CR GUIDANCE

The definition of modifiers and condition codes are available on the **PARA Data Editor Calculator** tab:

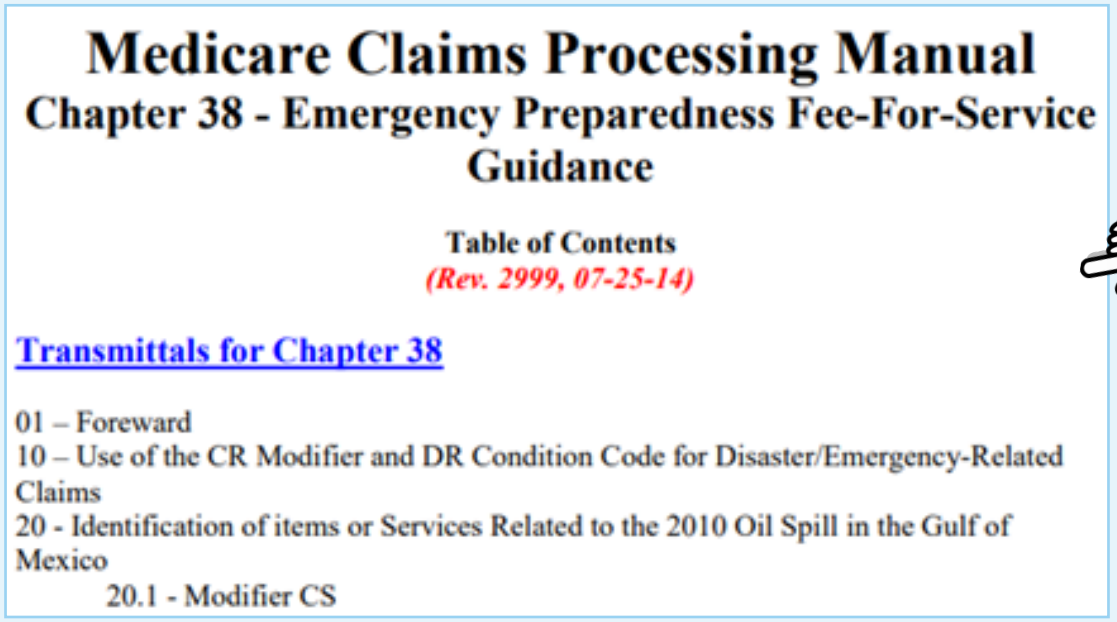




COVID-19 CONDITION CODE DR, MODIFIER CR GUIDANCE

The Medicare Claims Processing Manual, Chapter 38 – Emergency Preparedness For-Fee-Service Guidance provides additional information on the use of Modifier CR and Condition Code DR.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf



Medicare Claims Processing Manual

Chapter 38 - Emergency Preparedness Fee-For-Service Guidance

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(Rev. 2999, 07-25-14)

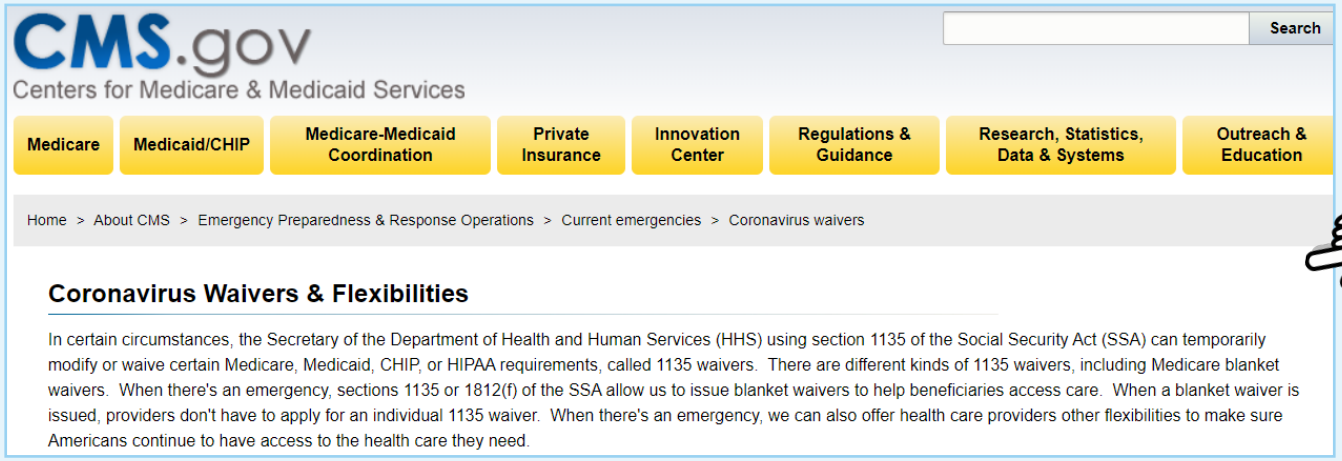
Transmittals for Chapter 38

01 – Foreward
10 – Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims
20 - Identification of items or Services Related to the 2010 Oil Spill in the Gulf of Mexico
20.1 - Modifier CS

While some commercial payers may instruct providers to bill according to CMS instructions, others may have unique billing guidelines; providers should consult the payer website or representative for billing guidance.

Each state may have additional waiver provisions as well.CMS Coronavirus Waivers & Flexibilities website provides a link for each applicable state:

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers



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Coronavirus Waivers & Flexibilities

In certain circumstances, the Secretary of the Department of Health and Human Services (HHS) using section 1135 of the Social Security Act (SSA) can temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements, called 1135 waivers. There are different kinds of 1135 waivers, including Medicare blanket waivers. When there's an emergency, sections 1135 or 1812(f) of the SSA allow us to issue blanket waivers to help beneficiaries access care. When a blanket waiver is issued, providers don't have to apply for an individual 1135 waiver. When there's an emergency, we can also offer health care providers other flexibilities to make sure Americans continue to have access to the health care they need.

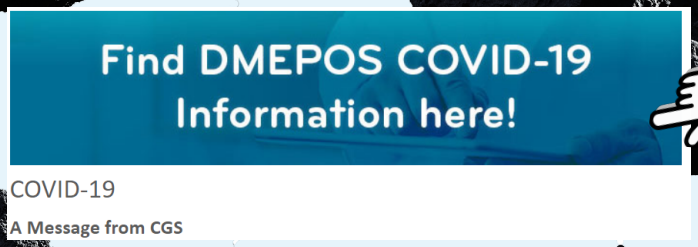
Additional Emergency/ Disaster Instructions may be provided by the Medicare Administrative Contractors (MACS) through their websites.

COVID-19 CONDITION CODE DR, MODIFIER CR GUIDANCE

WPS –Modifier CR Fact Sheet:

https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/modifier-cr/!ut/p/z0/fY2xDoIwFEV_BOfG5lVMCCsaDTEOjYOBLqYppTyFFtqifr7o5GAcz8299wCDEpjmd1Tco9G8m7li8eWYZXG2TGh-iApK02J3Xm2TfJ2clrAH9r8wP0S22BOK2MB9S1A3Bko1YS0d4bomVjozWSEdlL2psUFpibDvHV7HkaXAhNFePj2Uj8EFH9A-kFp16NqOejOgIGLOpA2p6Dj2LqS_BCH9Fgw3ViUuXbwA3O-mwg!!/

Noridian –Modifier CR: https://med.noridianmedicare.com/web/jddme/topics/modifiers/cr



CGS –COVID-19 (includes instructions for CR/DR):

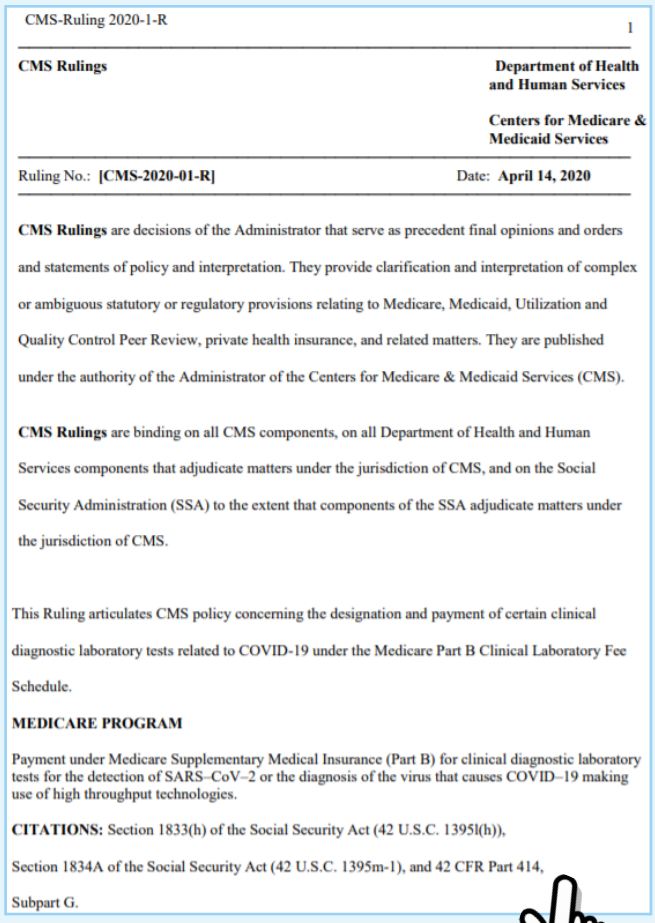
https://www.cgsmedicare.com/jb/covid-19.html

For more information about waivers, CMS has prepared a helpful slide presentation at:
https://www.cms.gov/files/document/cms-waivers-and-covid-19-response.pdf

CODING FOR HIGH THROUGHPUT COVID-19 TESTS

In **Ruling 2020-1-R** dated April 14, 2020, CMS announced two new HCPCS codes were created to report COVID-19 tests that require the use of high-throughput technologies. The ruling can be downloaded in its entirety using the link below:

https://www.cms.gov/files/document/cms-2020-01-r.pdf



CMS-Ruling 2020-1-R 1

CMS Rulings — **Department of Health and Human Services**

Centers for Medicare & Medicaid Services

Ruling No.: **[CMS-2020-01-R]** Date: **April 14, 2020**

CMS Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, private health insurance, and related matters. They are published under the authority of the Administrator of the Centers for Medicare & Medicaid Services (CMS).

CMS Rulings are binding on all CMS components, on all Department of Health and Human Services components that adjudicate matters under the jurisdiction of CMS, and on the Social Security Administration (SSA) to the extent that components of the SSA adjudicate matters under the jurisdiction of CMS.

This Ruling articulates CMS policy concerning the designation and payment of certain clinical diagnostic laboratory tests related to COVID-19 under the Medicare Part B Clinical Laboratory Fee Schedule.

MEDICARE PROGRAM

Payment under Medicare Supplementary Medical Insurance (Part B) for clinical diagnostic laboratory tests for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 making use of high throughput technologies.

CITATIONS: Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)), Section 1834A of the Social Security Act (42 U.S.C. 1395m-1), and 42 CFR Part 414, Subpart G.

U0003 (Infectious agent detection by nucleic acid (DNA or RNA) severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique), making use of high throughput technologies as described by CMS-2020-01-R).

Report U0003 in place of tests normally reported as 87635(infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique) **when high-throughput technology is used.**

U0004 (2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R).

HCPCS U0004 should be reported in place of U0002(2019-ncov coronavirus, sars-cov-2/2019-ncov (COVID-19), any technique, multiple types or subtypes (includes all targets), non-cdc.) **when high-throughput technology is used.**

A high-throughput machine requires specialized technical training and can process more than 200 specimens a day, which could be especially useful for nursing homes other sites which have larger Medicare populations.

Medicare will pay $100 under the Clinical Lab Fee Schedule for Part B services. These codes should not be used when testing for COVID-19 antibodies.CMS provides a partial list of accepted technology high-throughput machines:

- Roche cobas 6800 System
- Roche cobas 8800 System
- Abbott m2000 System
- Hologic Panther Fusion System
- GeneXpert Infinity SystemNeuMoDx 288 Molecular

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

In response to the public health declaration made on March 13, 2020, The California Department of Healthcare Services (DHCS) and Medi-Cal released a bulletin on March 19 2020 issuing guidance to providers, including but not limited to physicians, nurses, mental health practitioners, substance use disorder practitioners, dentists, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Tribal 638 Clinics. The guidance is pertinent to all participating providers to assist with providing medically necessary health care services for patients impacted by COVID-19.

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

The provisions for telehealth and COVID-19 include:

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

Telehealth and Virtual Communication Options

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

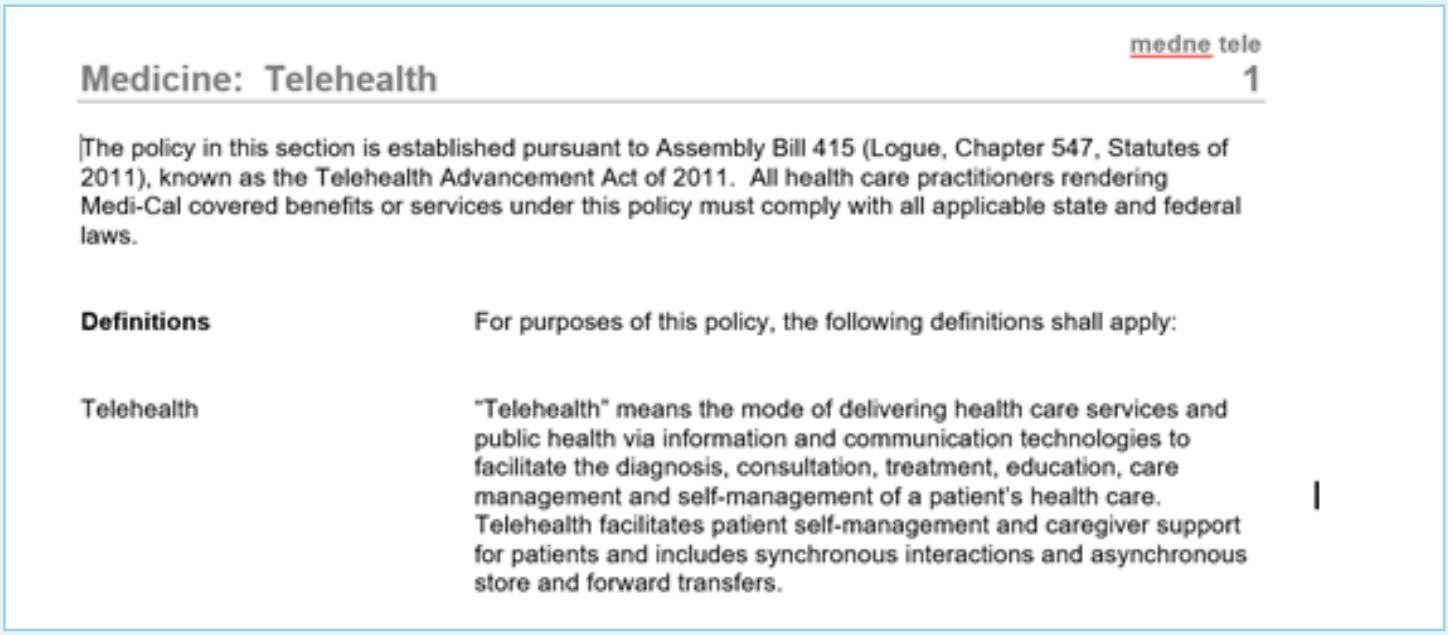
"Medi-Cal covered benefits and/or services, identified by Current Procedural Terminology (CPT®) and/or Healthcare Common Procedure Coding System (HCPCS) codes and subject to all existing Medi-Cal coverage and reimbursement policies, including any Treatment Authorization Request (TAR)/Service Authorization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

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

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

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

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



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Medicine: Telehealth 1

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

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

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

COVID-19 Update For Traditional Telehealth

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

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

COVID-19 Update For Synchronous Telehealth

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

- The treating practitioner at the distant site believes the Medi-Cal services being rendered are clinically appropriate based on evidence-based medicine and/or best practices to be delivered via telehealth, subject to oral or written consent by the Medi-Cal participant
- Examples of scenarios that would NOT be appropriate for delivery via telehealth:
  - Benefits or services that are performed in an operating room or while the patient is under anesthesia
  - Benefits or services that require direct visualization or instrumentation of bodily structures
  - Benefits or services that involve sampling of tissue or insertion/removal of medical devices

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

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

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

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

COVID-19 Medi-Cal Dental Benefits/Services Via Telehealth Update

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

- When reporting D9995 for services via teledentistry, Medi-Cal policy is as follows:
  - CDT code D9995 is reimbursed at 0.24 cents per minute, up to a maximum of 90 minutes or $21.60 maximum reimbursement.

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

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

The following table identifies the valid Medi-Cal Teledentistry codes that can be reported via asynchronous store and forward.

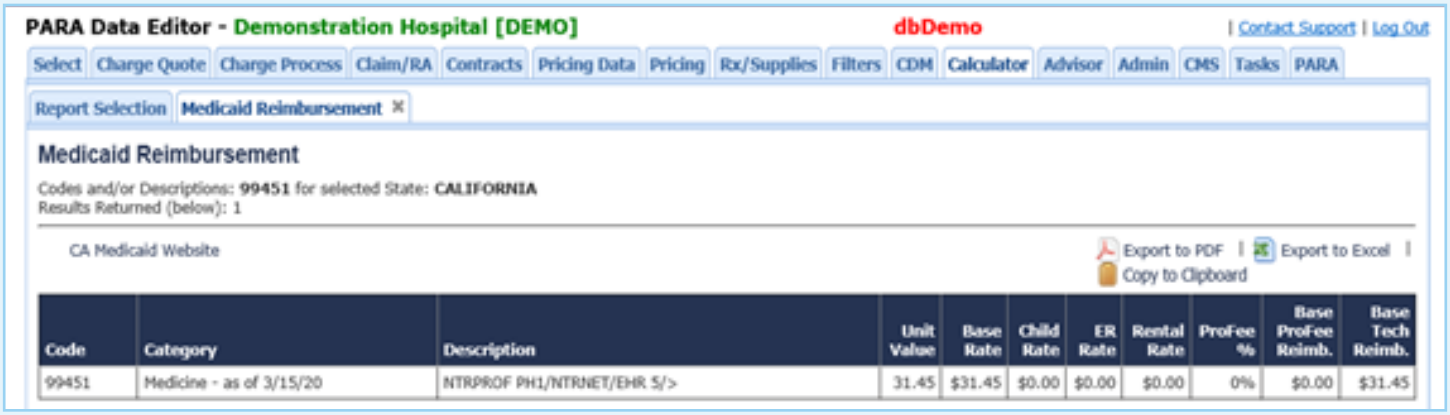
COVID-19 Medi-Cal Teledentistry	
Code	Description
D0120	Periodic oral evaluation – established patient
D0150	Comprehensive oral evaluation – new or established patient
D0210	Intraoral – complete series of radiographic images
D0220	Intraoral – periapical first radiographic image
D0230	Intraoral – periapical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

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

COVID-19 Asynchronous Store And Forward, Inclusive Of E-Consults Via Telehealth Update

Medi-Cal benefits are including but not limited to teleophthalmology, teledermatology, teledentistry and teleradiology. These services may all be delivered via asynchronous store and forward, including E-Consults, when all of the criteria outlined below are met by providers:

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

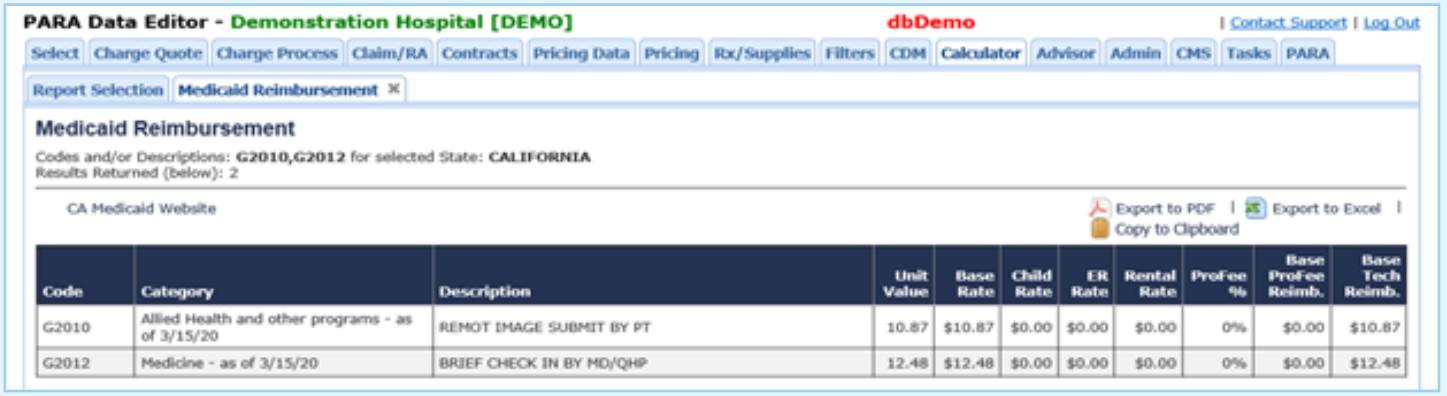


Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
99451	Medicine - as of 3/15/20	NTRPROF PH1/NTRNET/EHR 5/>	31.45	$31.45	$0.00	$0.00	$0.00	0%	$0.00	$31.45

COVID-19 Medi-Cal Other Virtual/Telephone Communication Update

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

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



Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
G2010	Allied Health and other programs - as of 3/15/20	REMOT IMAGE SUBMIT BY PT	10.87	$10.87	$0.00	$0.00	$0.00	0%	$0.00	$10.87
G2012	Medicine - as of 3/15/20	BRIEF CHECK IN BY MD/QHP	12.48	$12.48	$0.00	$0.00	$0.00	0%	$0.00	$12.48

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

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

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

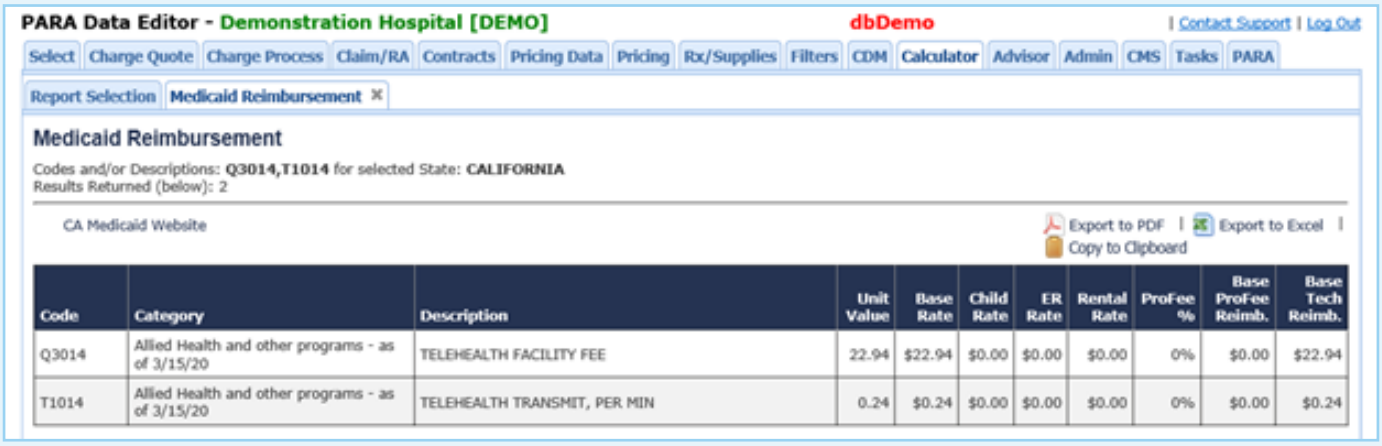
However, these services are **NOT billable** by:

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

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

COVID-19 Originating Site And Transmission Fee Updates

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



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

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

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

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

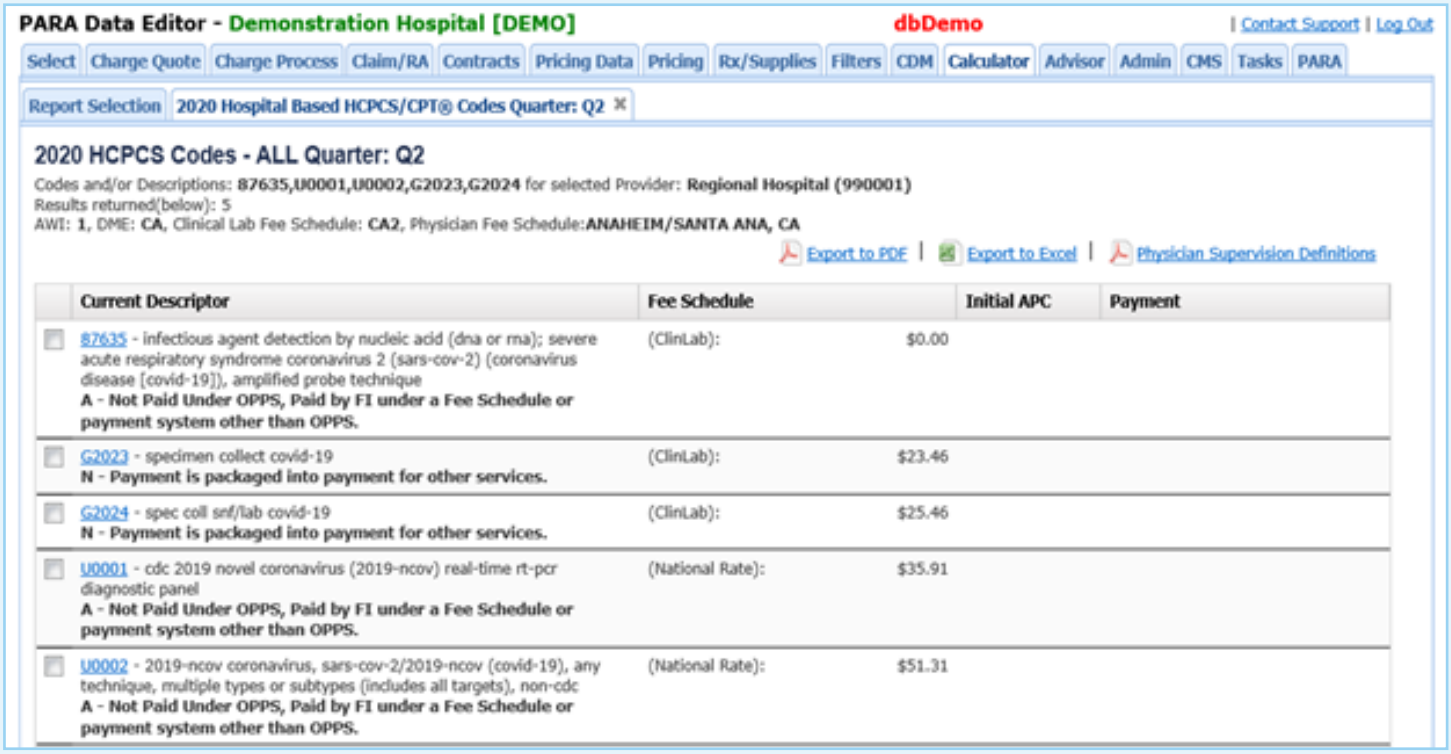
Laboratory Diagnostic Testing

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

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

Specimen collection codes under COVID-19: Effective for dates of service on or after March 1, 2020, HCPCS codes G2023 (specimen collect covid-19) and G2024 (spec coll snf/lab covid-19) are now Medi-Cal benefits.

The Centers for Medicare and Medicaid Services established two Level II HCPCS codes G2023 and G2024 for the specimen collection for COVID-19 testing. These codes are billable by clinical diagnostic laboratories.



Diagnosis Coding

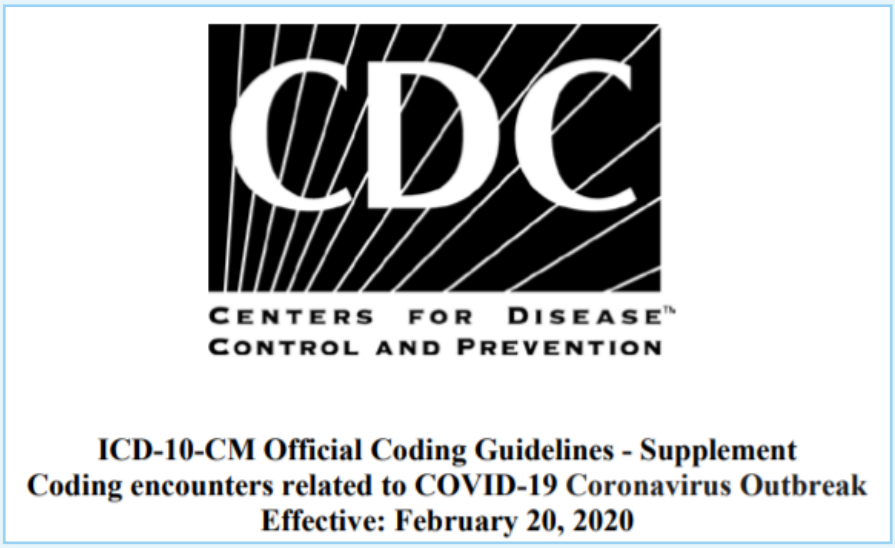
Currently, the Medi-Cal billing system is programmed to edit for any ICD-10 diagnosis codes identified by the Centers for Disease Control and Prevention (CDC) and the World Health Organization. DHCS is encouraging Medi-Cal participating providers to review the links below for assistance in diagnosis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

COVID-19 Diagnosis Update:

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

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

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

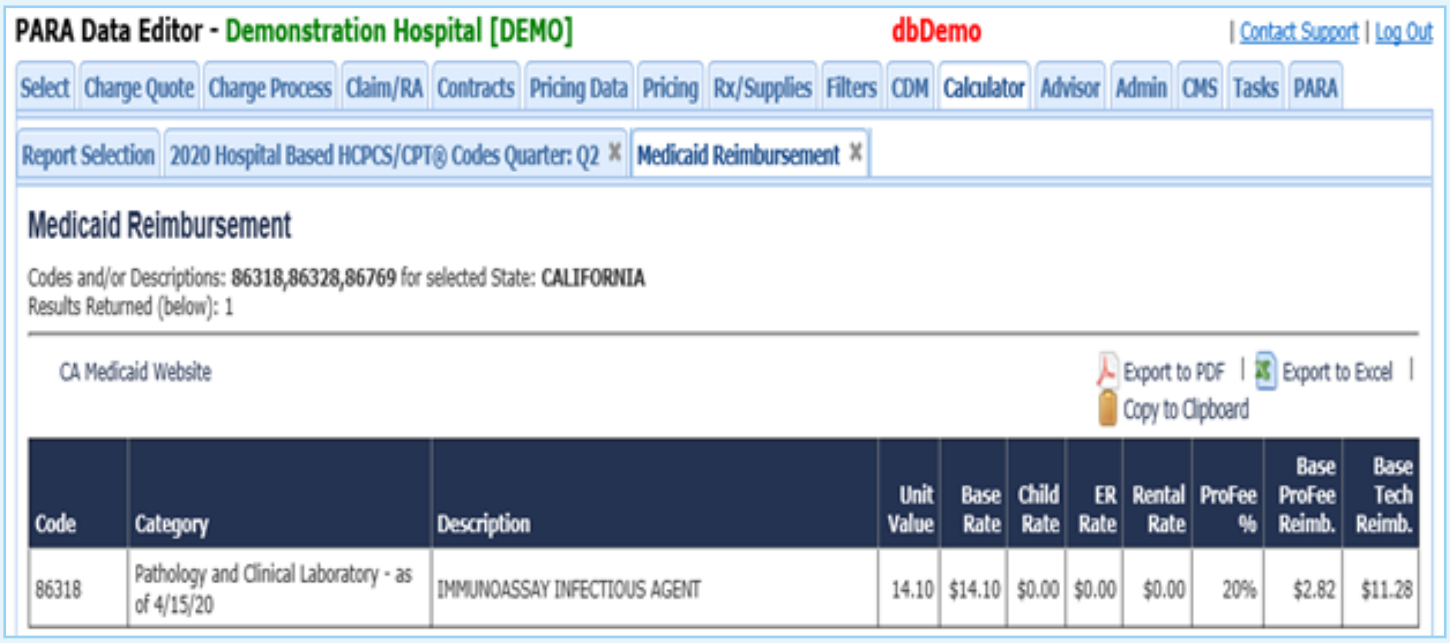


New: CPT® Codes For COVID-19 Antibody Testing

Effective for dates of service on or after April 10, 2020, the AMA has released CPT® codes 86318, 86328 and 86769 to allow for increased specificity to report serologic laboratory testing.

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

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



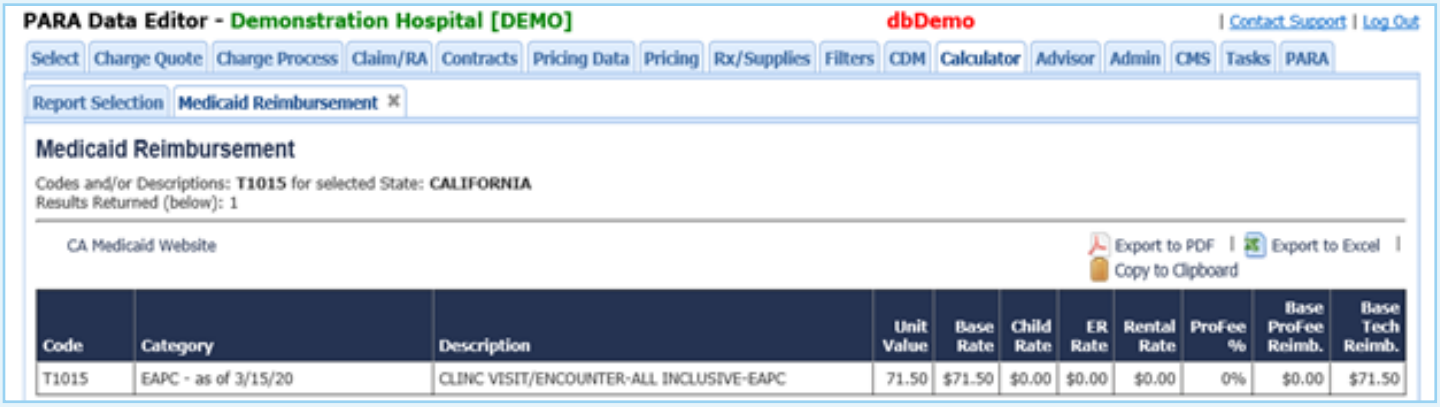
Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
86318	Pathology and Clinical Laboratory - as of 4/15/20	IMMUNOASSAY INFECTIOUS AGENT	14.10	$14.10	$0.00	$0.00	$0.00	20%	$2.82	$11.28

COVID-19 MEDI-CAL SERVICES AND TELEHEALTH NOTICE

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

For FQHCs, RHCs and Tribal 638 Clinics, participating providers may provide Medi-Cal covered benefits/services via synchronous telehealth to ESTABLISHED PATIENTS. Medi-Cal defines an established patient as those patients that have been seen at the FQHC, RHC or Tribal 638 Clinic within the last three (3) years.

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



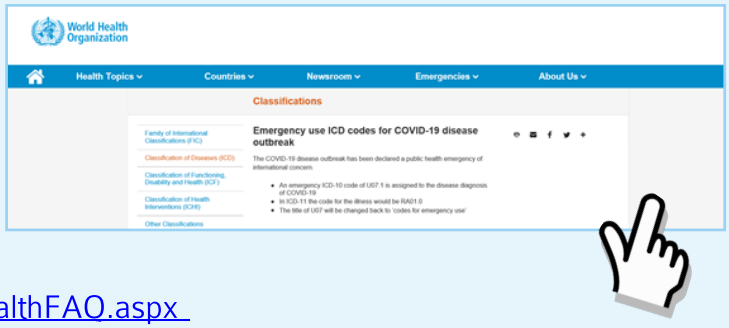
Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
T1015	EAPC - as of 3/15/20	CLINIC VISIT/ENCOUNTER-ALL INCLUSIVE-EAPC	71.50	$71.50	$0.00	$0.00	$0.00	0%	$0.00	$71.50

For COVID-19, FQHCs, RHCs and Tribal 638 Clinics, Medi-Cal covered benefits outside of the four walls, may be provided via synchronous telehealth for certain populations pursuant to applicable federal law, including migrant/seasonal workers, homeless individuals, and homebound individuals.

FQHCs, RHCs and Tribal 638 Clinics, cannot bill for e-Consults or telephone visits.

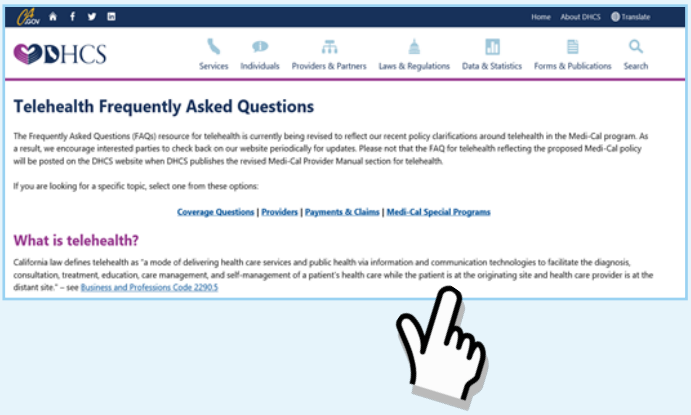
References for this article:

https://www.who.int/classifications/icd/covid19/en/



Providers that may have further questions regarding this update are encouraged to review the links below or call DHCS directly at 1-800-541-5555.

https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx



https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx

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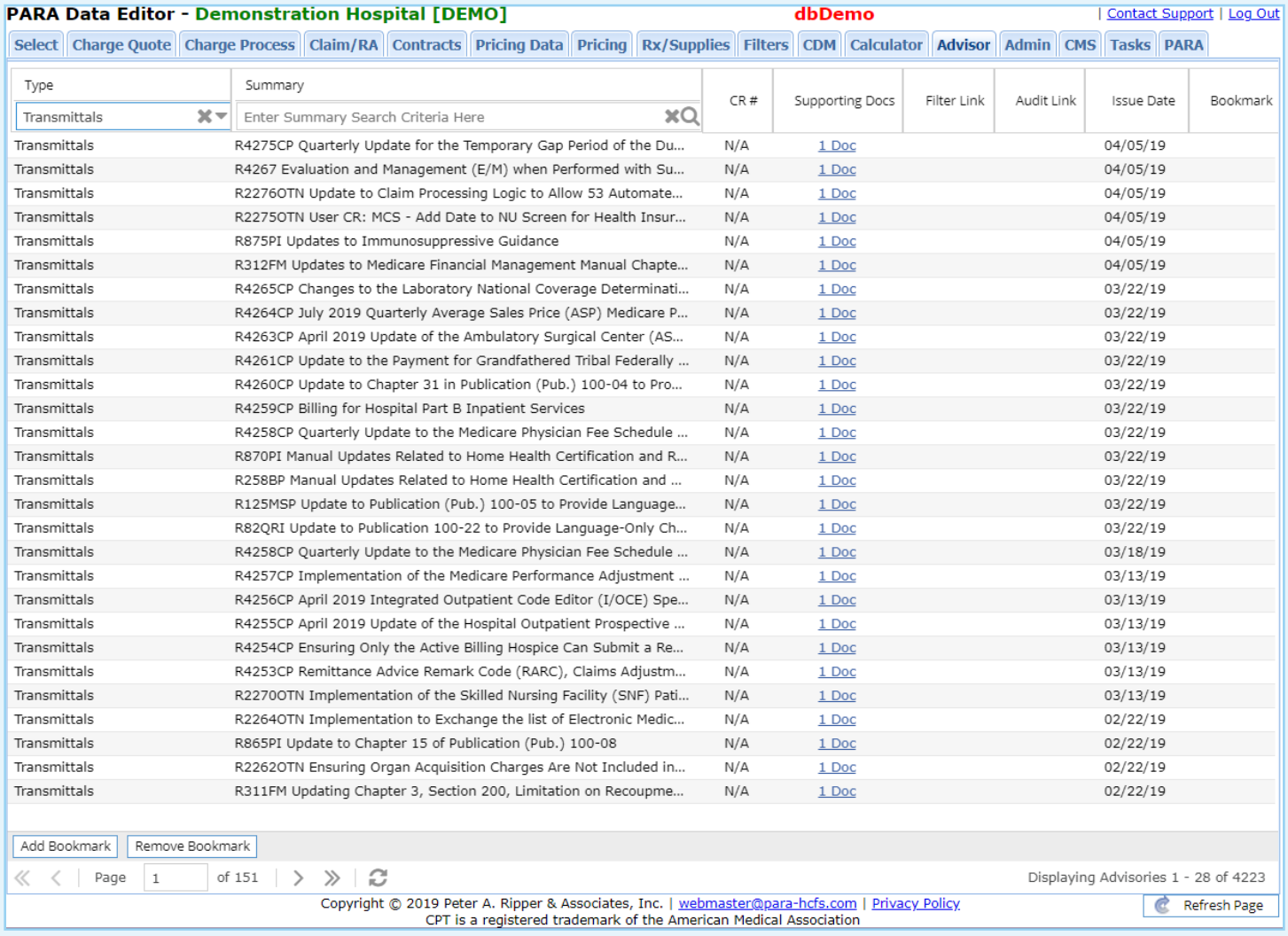

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Transmittals	R2276OTN Update to Claim Processing Logic to Allow 53 Automate...	N/A	1 Doc			04/05/19	
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KNOWLEDGE • RESOURCES • TRAINING

Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan

MLN Matters Number: MM11580

Related CR Release Date: May 1, 2020

Related CR Transmittal Number: R10071CP

Related Change Request (CR) Number: 11580

Effective Date: Claims received on or after October 1, 2020

Implementation Date: October 5, 2020

PROVIDER TYPES AFFECTED

This MLN Matters article is for providers, especially hospitals, submitting claims to Medicare Administrative Contractors (MACs) for Part A services provided to Medicare beneficiaries when a beneficiary's Medicare Advantage (MA) plan becomes effective during the inpatient admission.

WHAT YOU NEED TO KNOW

CR 11580 modifies Medicare system edits on inpatient claims when a beneficiary's MA plan becomes effective during the inpatient admission. Also, the Centers for Medicare & Medicaid Services (CMS) is streamlining the editing for MA plans' claims when it is determined that certain services are being disallowed on MA plans that are considered a significant cost under Section 422.109(a)(2) of title 42 of the Code of Federal Regulations (CFR). Original Fee-For-Service (FFS) Medicare will pay for services obtained by beneficiaries enrolled in MA plans in this circumstance.

BACKGOUND

When a Medicare beneficiary enrolls in an MA plan, the MA benefits replace traditional FFS claims payment. For inpatient claims (hospital claims paid under a prospective payment system), Medicare policy states that the payer at the time of admission will continue to be responsible for any inpatient stay when a beneficiary enrolls or dis-enrolls from an MA plan after the admission date and prior to the hospital discharge. When a beneficiary is admitted as an inpatient and does not have Part A hospital benefits remaining or benefits exhaust during the stay, Medicare allows the provider to submit a claim for ancillary services that are payable under Part B on Type of Bill (TOB) 012X. The beneficiary is still classified as an inpatient even though no Medicare Part A benefits are payable, as stated in 42 CFR 422.318.b.1.

CMS is aware of an issue where its Common Working File (CWF) is incorrectly rejecting TOB

CMS Medicare Learning Network

The link to this MedLearn MM11749

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KNOWLEDGE • RESOURCES • TRAINING

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

MLN Matters Number: MM11749

Related CR Release Date: May 1, 2020

Related CR Transmittal Number: R10092OTN

Related Change Request (CR) Number: 11749

Effective Date: October 1, 2020

Implementation Date: June 1, 2020 - local MACs; October 5, 2020 – Shared System Maintainers

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Change Request (CR) 11749 informs providers about updated International Classification of Diseases, 10th Revision (ICD-10) conversions as well as coding updates specific to National Coverage Determinations (NCDs). Please make sure your billing staffs are aware of these updates.

BACKGROUND

Previous NCD coding changes appear in ICD-10 quarterly updates that at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs.

Edits to ICD-10, and other coding updates specific to NCDs, will be included in subsequent quarterly releases as needed. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes, appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides, appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding.

CMS Medicare Learning Network

The link to this MedLearn MM11721

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KNOWLEDGE • RESOURCES • TRAINING

New Codes for Therapist Assistants Providing Maintenance Programs in the Home Health Setting

MLN Matters Number: MM11721 | Related Change Request (CR) Number: 11721

Related CR Release Date: May 1, 2020 | Effective Date: January 1, 2020

Related CR Transmittal Number: R10086CP | Implementation Date: October 5, 2020

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for therapy services to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11721 informs you of the changes to Home Health (HH) billing and processing instructions, including new G-codes that describe therapy assistant services. It also makes a correction to the processing of HH claims that receive episode sequence edits. Make sure that your billing staffs are aware of these changes.

BACKGROUND

Prior to January 1, 2020, the regulations at 42 CFR 409.44(c)(2)(ii)(C) stated that where the clinical condition of the patient is such that the complexity of the therapy services required to maintain function involves the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant) or the clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist himself/herself (and not an assistant) in order to ensure the patient's safety and to provide an effective maintenance program, then those reasonable and necessary services shall be covered.

In the CY 2020 Home Health Prospective Payment System (HH PPS) Rule, the Centers for Medicare & Medicaid Services (CMS) stated that it would be appropriate to allow therapist assistants to perform maintenance therapy services under a maintenance program established by a qualified therapist under the HH benefit, if acting within the therapy scope of practice defined by their state licensure laws. The qualified therapist would still be responsible for the:

- Initial assessment
- Plan of care

CMS Medicare Learning Network

The link to this MedLearn MM11559

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KNOWLEDGE • RESOURCES • TRAINING

Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy

MLN Matters Number: MM11559 Revised

Related Change Request (CR) Number: 11559

Related CR Release Date: April 30, 2020

Effective Date: July 1, 2020

Related CR Transmittal Number: R10095OTN

Implementation Date: July 6, 2020

Note: We revised this article to reflect a revised CR 11559, issued on April 30, 2020. The CR changes had no impact on the substance of the article. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters® Article is for physicians, hospitals, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

CR 11559 informs MACs about changes to Medicare Common Working File (CWF) edits to ensure the original 1-Day and 3-Day Payment Window edits' set and bypass conditions are consistent with current policy.

There are no policy changes. Current policy is in the Medicare Claims Processing Manual, Chapter 4, Section 10.12, "Payment Window for Outpatient Services Treated as Inpatient Services" and Chapter 3, Section 40.3, "Outpatient Services Treated as Inpatient Services".

ADDITIONAL INFORMATION

The official instruction, CR11559, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10095otn.pdf.

Note: The business requirements of CR11559 are effective for all dates of service processed on or after January 6, 2020.

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

CMS Medicare Learning Network

The link to this MedLearn MM11661

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

MLN Matters Number: MM11661 Revised | Related Change Request (CR) Number: 11661

Related CR Release Date: May 1, 2020 | Effective Date: January 1, 2020

Related CR Transmittal Number: R10098CP | Implementation Date: April 6, 2020

Note: We revised this article on May 4, 2020, to reflect the revised CR 11661, issued on May 1, 2020, to revise the relative value units for codes 99441, 99442, and 99443, and add information for codes G2025 and G0071, listed in the CR attachment. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries and reimbursed using the Medicare Physician Fee Schedule (MPFS).

PROVIDER ACTION NEEDED

This article informs you that the Centers for Medicare & Medicaid Services (CMS) issued payment files to the MACs based upon the 2020 MPFS Final Rule, published in the Federal register on November 15, 2019. CR 11661 amends those payment files. Make sure your billing staffs are aware of these changes.

BACKGROUND

Section 1848(c)(4) of the Social Security Act authorizes the Secretary of the Department of Health and Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians' services. The updated payment files are effective for services you furnish between January 1, 2020 and December 31, 2020.

Summary of Changes for April 2020

Below is a summary of the changes for the April update to the 2020 MPFS. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2020.

CMS Medicare Learning Network

There were FIVE new or revised Transmittals released this week.

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

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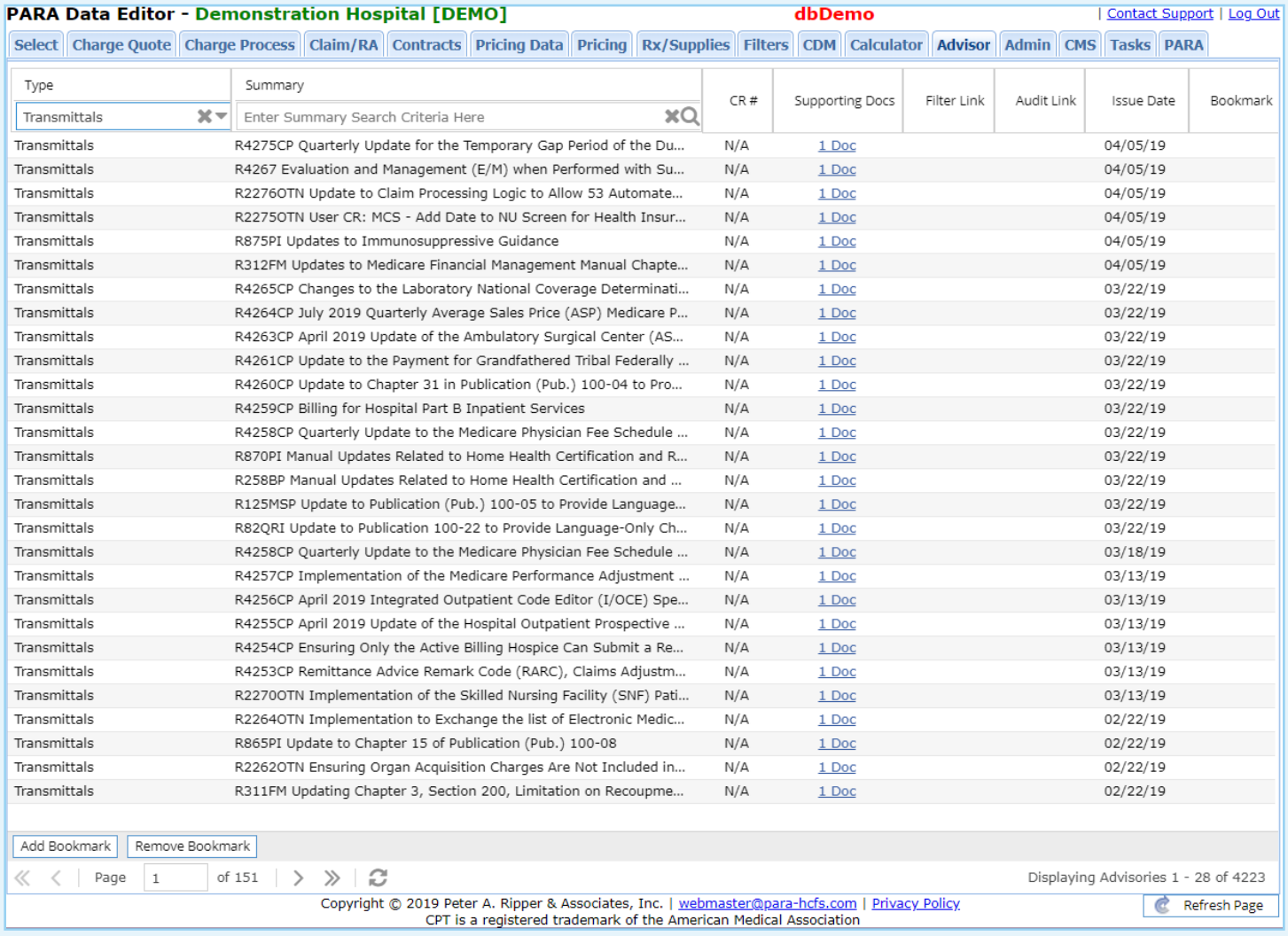

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The link to this Transmittal R10071CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10071	**Date: May 1, 2020**
	Change Request 11580

SUBJECT: Modify Edits in the Fee for Service (FFS) System When a Beneficiary has a Medicare Advantage (MA) Plan

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to modify edits that assign on inpatient claims when a beneficiary's MA plan becomes effective during the inpatient admission. In addition, we are modifying FFS edits that assign on claims for services that are not included in the MA capitation rate.

EFFECTIVE DATE: October 1, 2020 - For claims received on or after October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	32/66/66/National Coverage Determination (NCDs) services that are considered a significant cost for Medicare Advantage
N	32/66/66.1/Institutional Billing for National Coverage Determination (NCDs) services that are considered a significant cost for Medicare Advantage
N	32/66/66.2/Services Identified as having Significant Cost for Medicare Advantage

III. FUNDING:

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

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

The link to this Transmittal R10072CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10072	**Date: May 1, 2020**
	Change Request 11609

SUBJECT: Removal of Signature Line from Appeals Page of the Medicare Summary Notice (MSN) and MSN Envelope Correction

I. SUMMARY OF CHANGES: On May 7, 2019, CMS published a final rule, 84 FR 19855, which removes the requirement for signatures on appeal requests that are filed under 42 CFR Part 405, Subpart I. This final rule became effective July 8, 2019. MACs have been instructed through previously issued technical direction that effective July 8, 2019, MACs shall no longer dismiss appeal requests for lack of signature. Because of this, we are now instructing contractors to remove the signature line from the appeals page of the Medicare Summary Notice (MSN).

Also included in this change request (CR) is information correcting the text that should be displayed on MSN envelopes. There is conflicting information in the IOM and the MSN envelope exhibits posted online, so we are using this CR as an opportunity to correct this issue, since the envelope correction also involves changes to Chapter 21 of the IOM.

EFFECTIVE DATE: October 1, 2020
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IMPLEMENTATION DATE: October 5, 2020

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	21/10/3.8/ Specifications for Section 4 (Last Page): Denials and Appeals

III. FUNDING:
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IV. ATTACHMENTS:

The link to this Transmittal R10073CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10073	**Date: May 1, 2020**
	Change Request 11650

SUBJECT: National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM)

I. SUMMARY OF CHANGES: The purpose of this change request is to inform contractors that for dates of service on and after July 2, 2019, CMS will cover Ambulatory Blood Pressure Monitoring for the diagnosis of hypertension in Medicare beneficiaries under updated criteria.

EFFECTIVE DATE: July 2, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 16, 2020 - MAC local edits; October 5, 2020 - CWF, MCS, FISS edits

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II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/10.1/10.1 - Ambulatory Blood Pressure Monitoring (ABPM) Billing Requirements

III. FUNDING:

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IV. ATTACHMENTS:

Business Requirements
Manual Instruction

The link to this Transmittal R10092OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10092	**Date: May 1, 2020**
	Change Request 11749

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

I. SUMMARY OF CHANGES: This Change Request (CR) constitutes a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

Previous NCD coding changes appear in ICD-10 quarterly updates that can be found at: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, longstanding NCD process.

EFFECTIVE DATE: October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 1, 2020 - local MACs; October 5, 2020 - SSMs

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

III. FUNDING:
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IV. ATTACHMENTS:
One Time Notification

The link to this Transmittal R10089OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10089	**Date: May 1, 2020**
	Change Request 11728

SUBJECT: Implementation of the Error Scenario for the Document Code File (DCF) and Data Element Format Revisions for Providers Participating in the Electronic Medical Documentation Requests (eMDR) via the Electronic Submission of Medical Documentation (esMD) System

I. SUMMARY OF CHANGES: The purpose of this CR is to correct issues with the eMDR file format and Document Code File that were encountered during the January 2020 User Acceptance Testing period.

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

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

III. FUNDING:
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IV. ATTACHMENTS:

One Time Notification

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When you need extra strength, **PARA /HFRI** remote services can step in to continue seamless insurance accounts receivable collections.

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WHAT WE OFFER

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- Contingency-Based Flat Rate Fee Schedule
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- Staffing Shortages
- Recent Legacy Conversion
- Write-offs Over 2.5%
- Small Balance Accounts That Are Untouched For 30 Days
- Net A/R Days Greater Than 45

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