PARA HealthCare Analytics
HEALTHCARE FINANCIAL RESOURCES

September 2, 2020

PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS

Breakthrough Devices

Page 17

Ambulance Billing

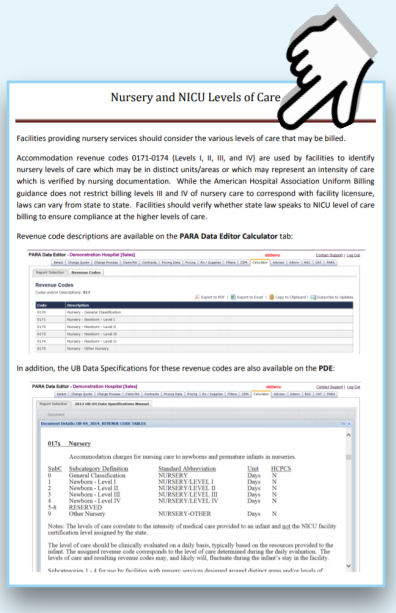
Page 4

SPECIAL NOTICE
PAGE 67

FAST LINKS

NEWBORN PHOTOTHERAPY

Q. What revenue code would you suggest be used to bill newborn phototherapy? There is no specific CPT®/HCPCS code for these services?


Nursery and NICU Levels of Care

Facilities providing nursery services should consider the various levels of care that may be billed.

Accommodation revenue codes 0171-0174 (Levels I, II, III, and IV) are used by facilities to identify nursery levels of care which may be in distinct units/areas or which may represent an intensity of care which is verified by nursing documentation. While the American Hospital Association Uniform Billing guidance does not restrict billing levels III and IV of nursery care to correspond with facility licensure, laws can vary from state to state. Facilities should verify whether state law speaks to NICU level of care billing to ensure compliance at the higher levels of care.

Revenue code descriptions are available on the **PARA Data Editor Calculator** tab:

In addition, the UB Data Specifications for these revenue codes are also available on the **PDE**:

A. **Answer:** We consider phototherapy performed on a newborn (inpatient) to be a component of the room charge – it should not be separately charged. Disposable supplies may be separately charged.

Our recommendation is not to charge extra for newborn phototherapy service. It is part of the room & board rate, just as any other "bedside procedure" performed by regularly assigned unit nursing personnel would be considered a component of the room and board rate.

Checking the sample chargemaster accommodation codes for nursery care seen here, according to the utilization charges we have on file for the 10 months ending August 2019, the hospital did not use the nursery R&B rate under revenue code 0172. According to the UB manual, that room rate may be appropriate for infants with jaundice, which is typically why a newborn is provided with phototherapy:

Show TPI Map
CDM: **4/1/2020**, NDC: **4/1/2020**, Cost: **1/1/1900**
Quantity Date Range: **10/1/2018** to **8/31/2019**

Department: **All** - **Items: 4**

	Procedure Code	Procedure Description	Exc	Qty	Price	CPT® /HCPCS				
						CPT_CODE	Medicare	Medicaid	ALT_CODE	REV_COD
1	7635 - 1100007	ROOM NEWBORN I	-	8,214	1,422.00					0171
2	7640 - 1100008	ROOM NEWBORN III	-	3,489	3,818.00					0173
3	7640 - 1100009	ROOM NEWBORN IV	-	2,208	4,661.00					0174
4	7640 - 1100021	ROOM NEWBORN II	-	-	3,129.00					0172

Attached is a paper which describes the different newborn accommodation revenue codes. Here's an excerpt:

Level II (Revenue Code 0172): Low birth-weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates (Continuing Care) - typically represents care for low birth weight babies which may not be sick but require additional nursing resources for additional frequent feedings and care. The babies are generally born at 32 weeks gestation and are not strong enough to eat well or stay warm on their own and may need to be placed in an incubator. They may also have jaundice or apnea of prematurity.

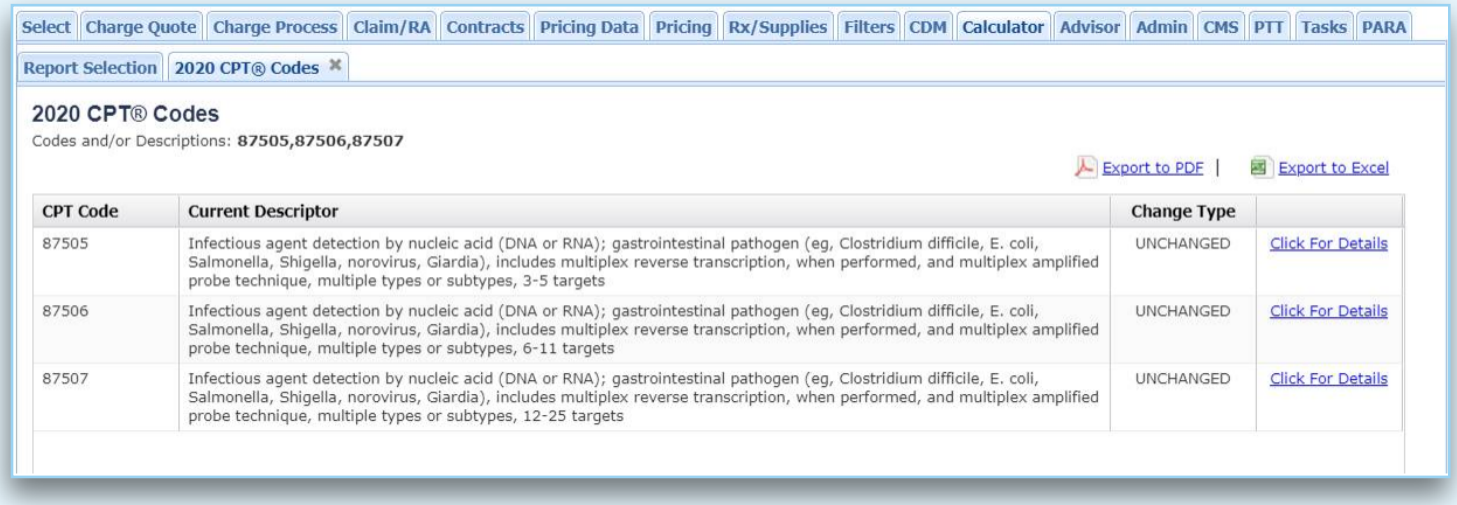
Attached is **PARA's** paper on bedside procedures, which holds that services performed for inpatients by regularly assigned unit nursing personnel should not be separately charged, as well as our paper describing the different revenue codes for nursery room charges.reimbursement under commercial plans will be as generous as Medicare's reimbursement for high-throughput processing.

LAB CODES

Q. When charging CPT® codes 87505, 87506 and/or 87507, do the listed organisms all need to be tested for? Can non listed organisms be billed using these CPT®s? Or should the determining factor be simply the number of targets probed? Our reference labs suggest using these CPT®s when we order their 'Viral GI PCR Panel' and although Norovirus is included (and listed in the CPT®), this is the only organism tested that is in the CPT® list. The other viruses this panel include are Rotavirus, Adenovirus, Sapovirus, and Human Astrovirus. What is the proper method of billing this?

A. **Answer:** Report CPT® codes 87505, 87506 and 87507 based on the number of targets probed. The pathogens listed in the code description are used for examples (e.g.) so it isn't an all-inclusive list. Assign 87505 for evaluation of Norovirus, Rotavirus, Adenovirus, Sapovirus and Human Astrovirus pathogens since this code includes 5 targets.

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



AMBULANCE BILLING -- PARAMEDIC INTERCEPT

Q. Our Advanced Life Support (ALS) ambulance is located in a rural area, and sometimes is called upon to meet a Basic Life Support (BLS) ambulance transporting a critically ill or injured patient originating from a very remote area, where there are no ALS ambulances. Our paramedics will meet a basic life support ambulance service coming from the distant area and transfer the patient from the BLS rig to our ALS rig, in which our paramedics can provide a higher level of care than the BLS provider can offer. We would like to know whether this qualifies as a "Paramedic Intercept", and could be billed with HCPCS A0432.

A. **Answer:** Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. Since the scenario described includes two different ambulances each transporting the patient for different sections of the journey to reach hospital care, A0432 is not an appropriate code. Instead, for the case you described, each ambulance service may bill for its own level of care and mileage to/from the point of transfer.

A Paramedic Intercept (A0432) is billable in very limited circumstances. Currently, the qualifying conditions exist only in some of the western counties of New York state. Here is an excerpt from Medicare's publication "Ambulance Fee Schedule and Medicare Transports" (July 2019):

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf

- **Paramedic Intercept (PI)** – When an entity that does not provide the ambulance transport provides ALS services, PI may be required when you can provide only a BLS level of service and the beneficiary requires an ALS level of service (such as electrocardiogram monitoring, chest decompression, or intravenous therapy). Certain additional requirements apply that, as of the publication of this booklet, are met only by certain entities operating in some western counties of New York State.

The full list of requirements for a Paramedic Intercept is published in Chapter 10 of the Medicare Benefits Policy Manual:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf#

30.1.1 - Ground Ambulance Services

(Rev. 236, Issued: 06-16-17, Effective: 09-18-17, Implementation: 09-18-17)

...

Paramedic Intercept (PI)Definition: Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only BLS level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital.

The ALS paramedics then provide services to the patient.This tiered approach to life saving is cost effective in many areas because most volunteer ambulances do not charge for their services and one paramedic service can cover many communities. Prior to March 1, 1999, Medicare payment could be made for these services, but could not be made directly to the intercept service provider; rather, Medicare

AMBULANCE BILLING -- PARAMEDIC INTERCEPT

payment could be made only when the claim was submitted by the entity that actually furnished the ambulance transport. In those areas where state laws prohibited volunteer ambulances from billing Medicare and other health insurance, the intercept service could not receive payment for treating a Medicare beneficiary and was forced to bill the beneficiary for the entire service. Paramedic intercept services furnished on or after March 1, 1999, are payable separate from the ambulance transport when all of the requirements in the following three conditions are met:

I.The intercept service(s) is:

- Furnished in a rural area (as defined below);
- Furnished under a contract with one or more volunteer ambulance services; and,
- Medically necessary based on the condition of the beneficiary receiving the ambulance service

II.The volunteer ambulance service involved must:

- Meet Medicare's certification requirements for furnishing ambulance services;
- Furnish services only at the BLS level at the time of the intercept; and,
- Be prohibited by state law from billing anyone for any service

III.The entity furnishing the ALS paramedic intercept service must:

- Meet Medicare's certification requirements for furnishing ALS services, and,
- Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries

For purposes of the Paramedic Intercept benefit, a rural area is an area that is designated as rural by a state law or regulation or that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent version of the Goldsmith Modification). (The Goldsmith Modification is a methodology to identify small towns and rural areas within large metropolitan counties that are isolated from central areas by distance or other features). The current list of these areas is periodically published in the Federal Register. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 15, "Ambulance," §20.1.4 for payment of paramedic intercept services.

As another point of information, the Medicare Claims Processing Manual also offers instructions for billing a "Joint Response" – in which one entity provides the ALS personnel, but another BLS entity provides the transport. If a BLS ambulance responds to transport a patient and has an agreement with another entity to provide ALS services, including an ALS assessment, the BLS provider may submit a claim for an ALS transport. This arrangement is covered by Medicare under the category of "Joint Response" in the following section Medicare Benefits Policy Manual:

10.5 - Joint Responses

(Rev. 125, Issued 05-14-10, Effective: 01-04-10, Implementation: 06-15-10)

A.BLS/ALS Joint ResponsesIn situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, Paramedic Intercept services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists prior to submitting the Medicare claim. Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their A/B MAC (A) or (B)

CMS PROVIDES HCPCS PROCEDURE LIST FOR MODIFIER CS

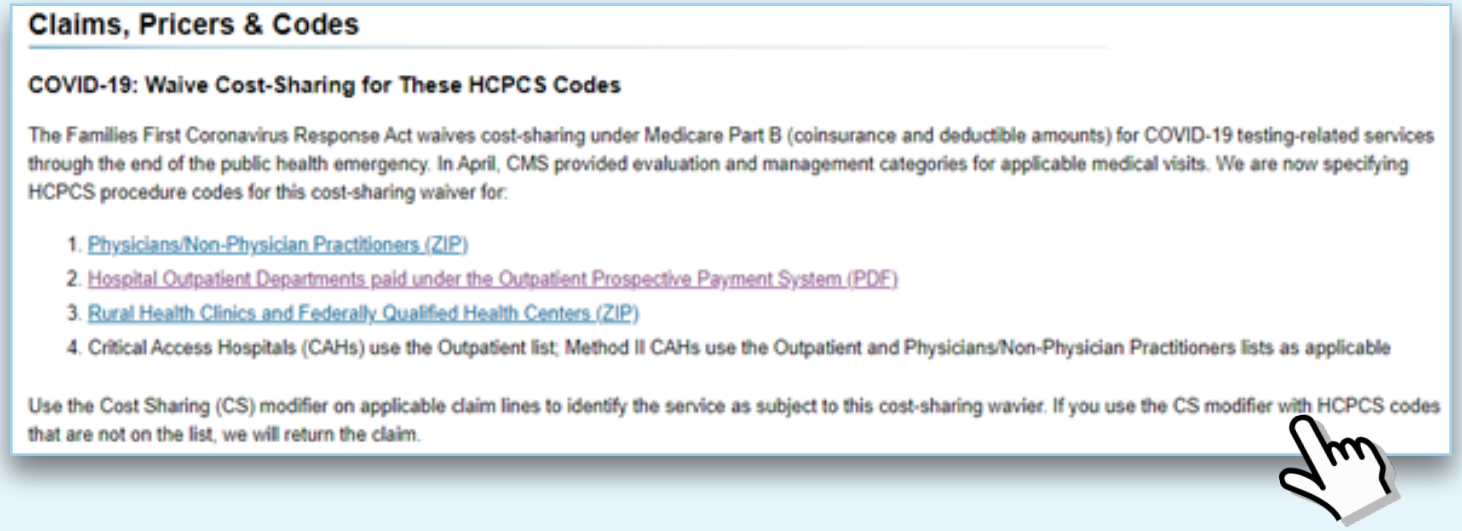
On August 27, 2020, CMS clarified the correct use of modifier CS by providing a list of HCPCS codes which are appropriate for waiving cost-sharing for physicians, hospitals, and RHCs/FQHCs when providing medically necessary COVID-19 related Medicare Part B services. CMS waives beneficiary coinsurance and deductible amounts for these services when Modifier CS is appended. CMS will return claims containing modifier CS on procedure codes which are not listed.

CMS provides separate lists of CS-eligible HCPCS code for three categories of medical providers:

- Physicians/Non-physician Practitioners
- Hospital OPPS Outpatient Departments
- RHCs and FQHCs

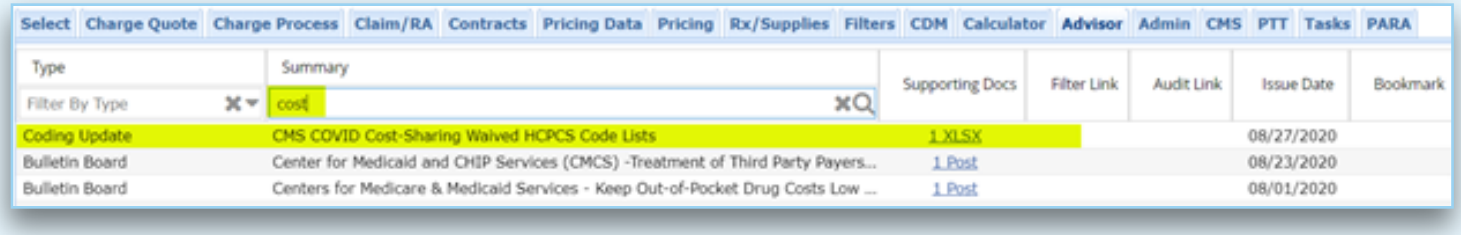
The document instructs Critical Access Hospitals to use the lists applicable to their billing method (Method I or Method II.)

https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-08-27-mlnc#_Toc49329805



CMS PROVIDES HCPCS PROCEDURE LIST FOR MODIFIER CS

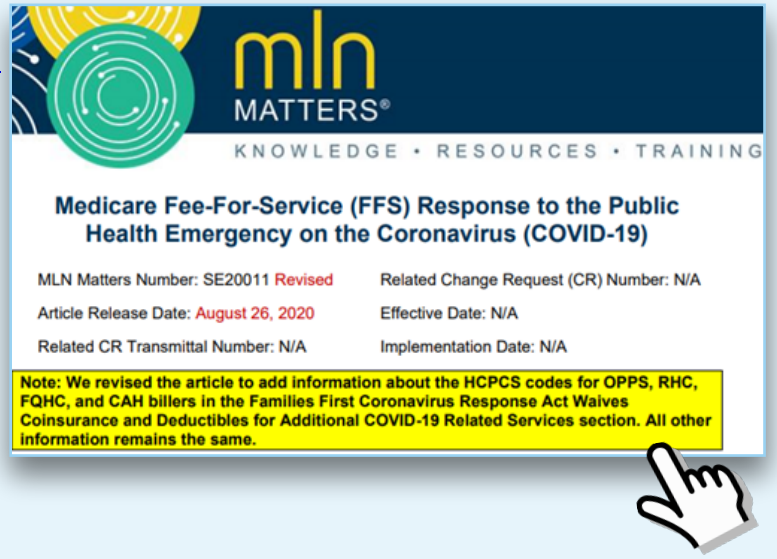
The CMS spreadsheet is available in the Advisor tab of the **PARA Data Editor**. Enter "Cost" in the summary field for quick access:



CMS also revised its MLN on Medicare Fee-For-Service Response to the PHE on Coronavirus.

The update can be found using the link below:

https://www.cms.gov/files/document/se20011.pdf



Additionally, CMS continues to update tje "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing" document posted on the CMS "Current Emergencies" website.

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

15. Question: Can physicians/NPPs apply the Cost Sharing (CS) modifier to claims for pre-surgery examination services that include COVID-19 testing?
Answer: The CS modifier should not be used when pre-surgery examination services are not paid separately, for example if particular services are considered to be part of services with a global surgical period, End Stage Renal Disease (ESRD) services with a monthly capitation payment or maternity package services.

During the COVID-19 PHE, the modifier can be reported with separately reported visit codes that result in an order for or administration of a COVID-19 test, when they are related to furnishing or administering such a test or are for the evaluation of an individual for purposes of determining the need for such a test.
New: 7/28/20

OCTOBER 1, 2020 OPPS HCPCS UPDATE

CMS released documents with details of the October, 2020 OPPS Update and the Integrated Outpatient Code Editor update on August 28, 2020. **PARA** chargemaster clients will be notified by email prior to 10/1/2020 of any required chargemaster updates. Links are provided on the last page of this paper.

Specifically, the OPPS updates to HCPCS codes include the following actions:

- Reaffirms and updates COVID-19 Lab Testing HCPCS – repeating previously established codes and adding new codes developed since the 7-1-2020 update
    - **U0001** CDC 2019 Novel Coronavirus (2019-nCoV) RealTime RT-PCR Diagnostic Panel; Effective 2/4/2020, OPPS Status A
    - **U0002** 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC;Effective 2/4/2020, OPPS Status A
    - **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; Effective 3/13/2020, OPPS Status A
    - **86328** Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); Effective 4/10/2020; OPPS status A
    - **86408** Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen; Effective 8/10/2020, OPPS status A
    - **86409** Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer 08/10/2020 A N/A 86769 Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) 04/10/2020 A N/A 87426 Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzymelinked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]); Effective 6/25/2020, OPPS status A
    - **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; Effective 4/14/2020, OPPS status A
    - **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; Effective 4/14/2020, OPPS status A

OCTOBER 1, 2020 OPPS HCPCS UPDATE

- **0202U** Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected 05/20/2020 A N/A 0223U Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected; Effective 6/25/2020, OPPS status A

- **0224U** Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s), when performed; Effective 6/25/2020, OPPS Status A

- **0225U** Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected; Effective 8/10/2020, OPPS status A

- **0226U** Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), ELISA, plasma, serum ; Effective 8/10/2020, OPPS status A

- **G2023** Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source; Effective 3/1/2020, OPPS status B

- **G2024** Specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source; Effective3/1/2020, OPPS status B

- **0014M** Liver disease, analysis of 3 biomarkers (hyaluronic acid [ha], procollagen iii amino terminal peptide [piiinp], tissue inhibitor of metalloproteinase 1 [timp-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver-related clinical events within 5 years; Effective 4/1/2020, OPPS status Q4

- **C9803** Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sarscov-2) (coronavirus disease [covid-19]), any specimen source; Effective 03/01/2020, OPPS status Q1

Adds three new surgical HCPCS Codes:

- **C9761** Describing Vacuum Aspiration of the Kidney, Collecting System and Urethra (OPPS status J1)

- **C9768** Describing Endoscopic Ultrasound-guided Direct Measurement of Hepatic Portosystemic Pressure Gradient (OPPS status N)

- **C9769** Describing Cystourethroscopy with Insertion of a Temporary Prostatic Implant or Stent with Anchor and Incisional Struts (OPPS status J1)

OCTOBER 1, 2020 OPPS HCPCS UPDATE

Adds two new CPT® Administrative Codes for Multianalyte Assays with Algorithmic Analyses (MAAA), and assigns them OPPS status Q4 (payment often packaged)

- **0015M** Adrenal cortical tumor, biochemical assay of 25 steroid markers, utilizing 24-hour urine specimen and clinical parameters, prognostic algorithm reported as a clinical risk and integrated clinical steroid risk for adrenal cortical carcinoma, adenoma, or other adrenal malignancy

- **0016M**- Oncology (bladder), mRNA, microarray gene expression profiling of 209 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as molecular subtype (luminal, luminal infiltrated, basal, basal claudin-low, neuroendocrine-like)

Establishes payment policy for 20 new CPT® Proprietary Laboratory Analyses (PLA) Codes (0203U through 0221U) Effective October 1, 2020

Adds 18 new HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, Radiopharmaceuticals, and skin substitutes

- 8 new codes will be assigned Pass-Through Status (separately payable)
  - C9060 Fluoroestradiol F18, diagnostic, 1 mCi
  - C9062 Injection, daratumumab 10 mg and hyaluronidase-fihj
  - C9064 Mitomycin pyelocalyceal instillation, 1 mg
  - C9065 Injection, romidepsin, non-lypohilized (e.g. liquid), 1mg
  - C9066 Injection, sacituzumab govitecan-hziy, 10 mg
  - C9067 Gallium ga-68, dotatoc, diagnostic, 0.01 mCi
  - J7351 Injection, bimatoprost, intracameral implant, 1 microgram
  - J9227 Injection, isatuximab-irfc, 10 mg

- 2 new drug HCPCS will be status E2, excluded – but status may change next quarter
  - J1437 Injection, ferric derisomaltose, 10 mg
  - J9304 Injection, pemetrexed (PEMFEXY), 10 mg

- 4 new HCPCS will replace drugs with temporary C-codes, all remain pass-thru status G:
  - J1632 Inj., brexanolone, 1 mg -- replaces C9055
  - J1738 Inj. meloxicam 1 mg – replaces C9059
  - J3241 Inj. teprotumumab-trbw 10 mg – replaces C9061
  - J3032 Inj. eptinezumab-jjmr 1 mg – replaces C9063

- 4 new skin substitute codes will be status N, payment packaged
  - Q4249 Amniply, for topical use only, per square centimeter
  - Q4250 AmnioAMP- MP, per square centimeter

OCTOBER 1, 2020 OPPS HCPCS UPDATE

- Q4254 Novafix dl, per square centimeter
- Q4255 Reguard, for topical use only, per square centimeter

Updates the status of three existing HCPCS Codes to Pass-Through Status

- Q5112 Injection, trastuzumab-dttb, biosimilar, (ontruzant), 10 mg (prior status K)
- Q5113 Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg (prior status K)
- Q5121 Injection, infliximab-axxq, biosimilar, (avsola), 10 mg (prior status E2)

Stops pass through status forQ5121(Infliximab-axxq, biosimilar (avsola) 10 mg., effective September 30, 2020

Revises the long descriptor forJ9305(injection pemetrexed, 10 mg) to "Injection, pemetrexed, not otherwise specified, 10 mg"

Implements the regular quarterly update to drug payment rates which are based on the Average Sales Price, including some retroactive updates.

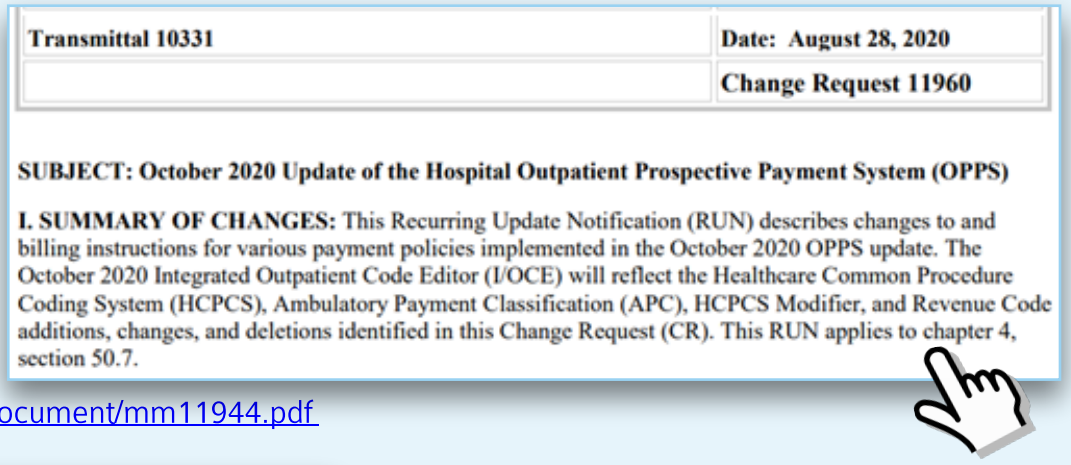
Reassigns 3 skin substitute HCPCS to the "High Cost Skin Substitute Group" as of 10/1/20 – this means that the corresponding skin substitute application code for these products must be reported using the 15271-15278 codes set for OPPS hospitals (if a low-cost skin substitute is reported, OPPS hospitals must use the C5271-C5278 application code set.)

- Q4205 Membrane graft or wrap sq cm
- Q4226 Myown harv prep proc sq cm
- Q4234 Xcellerate, per sq cm

Full details of the update are available at the link below:

https://www.cms.gov/files/document/r10331cp.pdf

Readers interested in additional updates to the Integrated Outpatient Code Editor, which includes ICD10 updates (among many other changes), should visit the following webpage:

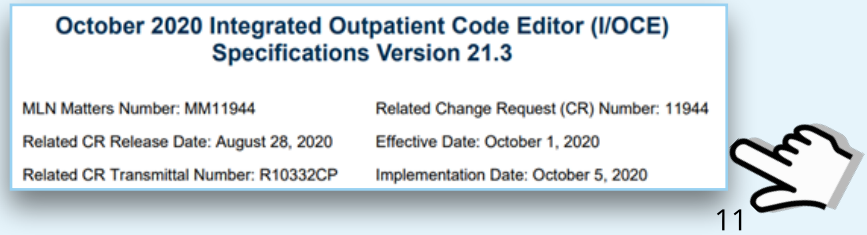


Transmittal 10331	Date: August 28, 2020
	Change Request 11960

SUBJECT: October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Recurring Update Notification (RUN) describes changes to and billing instructions for various payment policies implemented in the October 2020 OPPS update. The October 2020 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). This RUN applies to chapter 4, section 50.7.

https://www.cms.gov/files/document/mm11944.pdf



October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3

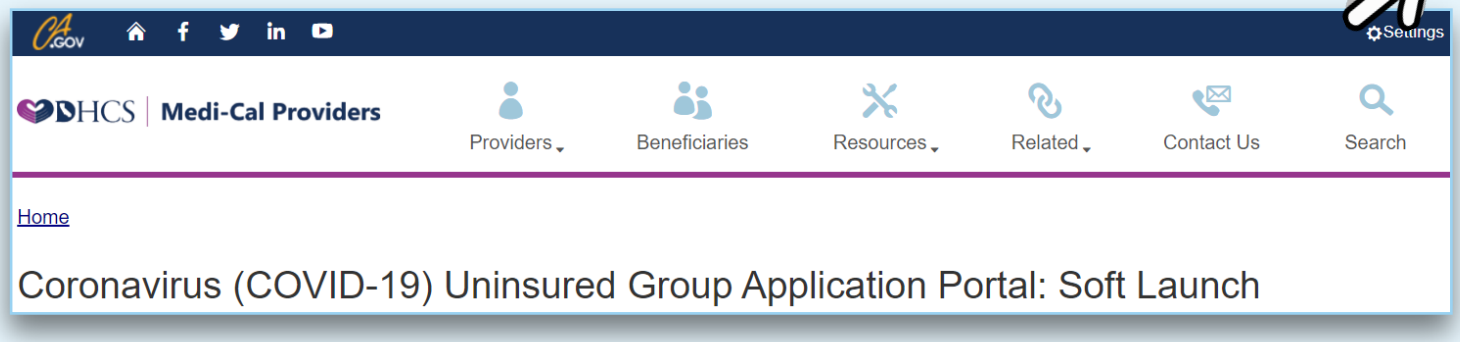
MLN Matters Number: MM11944	Related Change Request (CR) Number: 11944
Related CR Release Date: August 28, 2020	Effective Date: October 1, 2020
Related CR Transmittal Number: R10332CP	Implementation Date: October 5, 2020

COVID-19 UNINSURED GROUP APPLICATION PORTAL SOFT LAUNCH

Effective August 28th, 2020 the California Department of Health Care Services (DHCS) launched the Coronavirus (COVID-19) Uninsured Group Application Portal in a soft launch format.This enables certain providers to submit applications for temporary coverage of low-income COVID-19 patients under Medi-Cal's presumptive eligibility (PE) program.

The COVID-19 Uninsured Group program provides temporary, no-cost diagnostic testing, testing-related services and treatment services, including all medically necessary care. This includes associated office, clinic, or emergency room visits related to COVID-19. This program is available to uninsured individuals determined eligible by a Qualified Provider (QP) based on preliminary applicant information.

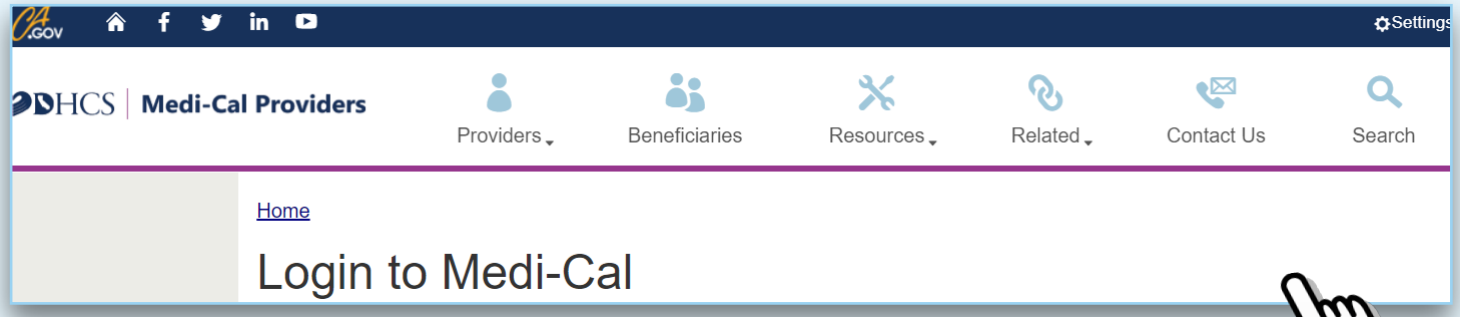
https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_85.aspx



The portal was created to provide access to the following providers who may not have access to the existing COVID-19 workaround to enter income requirements to submit a Presumptive Eligibility (PE) for COVID-19:

- QPs of Presumptive Eligibility for Pregnant Women (PE4PW)
- QPs for Breast and Cervical Cancer Treatment Program (BCCTP)
- QPs for Hospital Presumptive Eligibility (HPE) program
- QPs for Child Health & Disability Prevention Program (CHDP)

These QPs (PE4PW, BCCTP, HPE, and CHDP) **will have access** to the COVID-19 Group Application Portal. The income requirements at this time are stated as $99,999 per month and a household size of 98 people. Participating QPs should use the new COVID-19 Uninsured Group Application Portal in the Transactions area located on the California Medi-Cal Website:

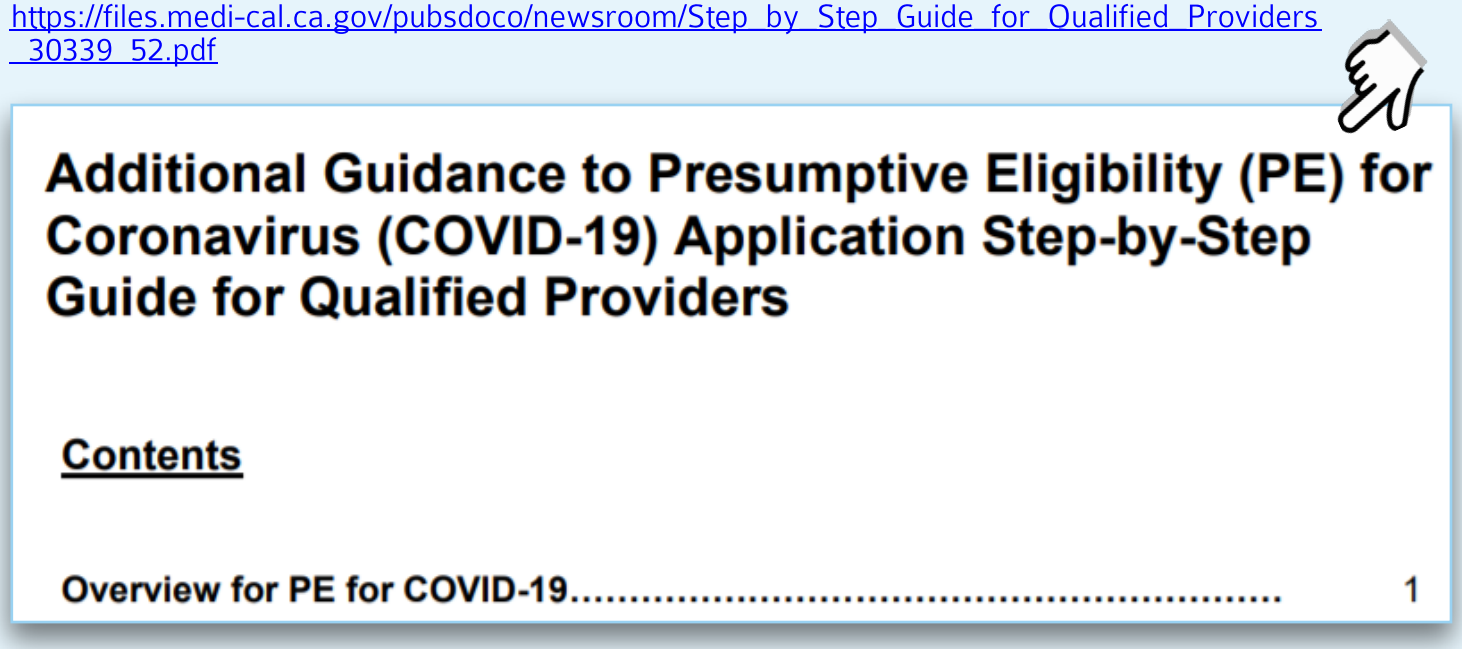


COVID-19 UNINSURED GROUP APPLICATION PORTAL SOFT LAUNCH

If QPs are unable to access the new COVID-19 Uninsured Group Application Portal, providers are being asked to use the existing manual process to submit a presumptive eligibilityfor COVID-19 Application.

For further assistance on how to do this, please review the web link below:

https://files.medi-cal.ca.gov/pubsdoco/newsroom/Step_by_Step_Guide_for_Qualified_Providers_30339_52.pdf



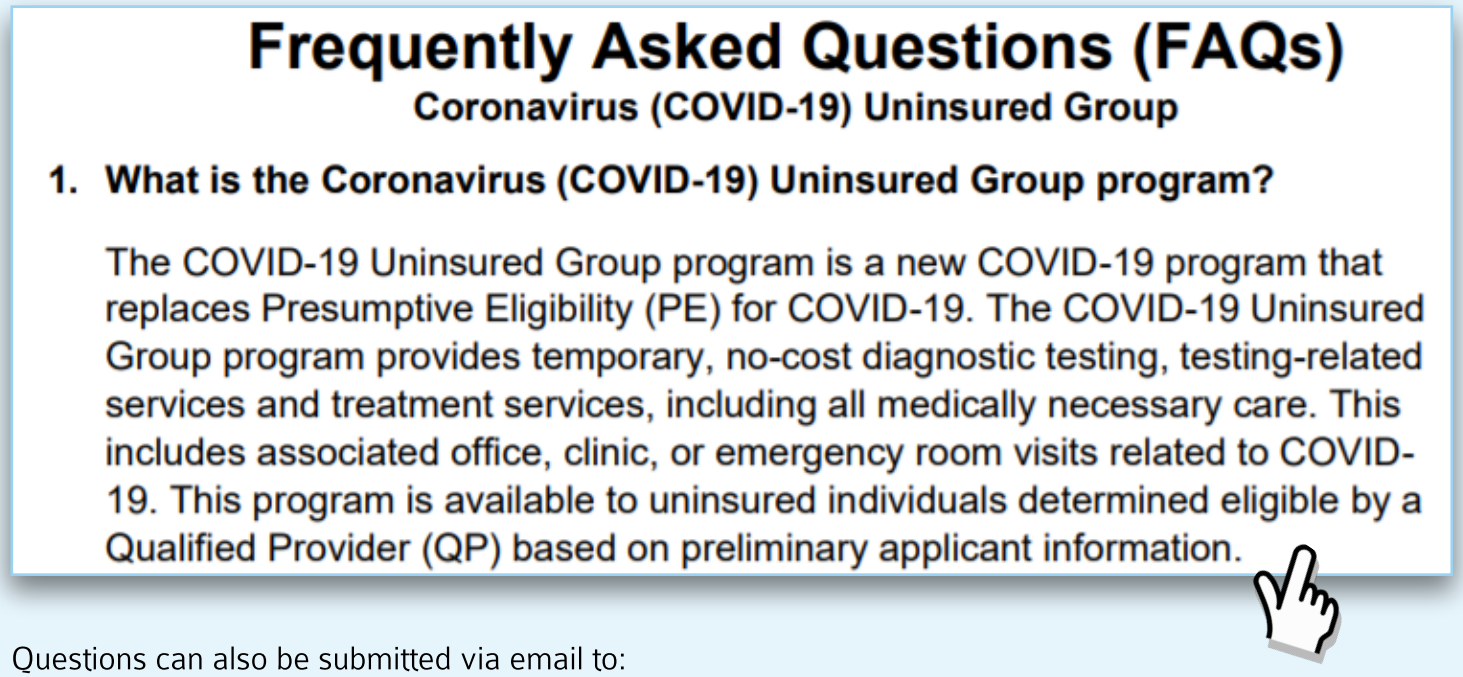
Additional Guidance to Presumptive Eligibility (PE) for Coronavirus (COVID-19) Application Step-by-Step Guide for Qualified Providers

Contents

Overview for PE for COVID-19..... 1

Link to updated FAQ for COVID-19

https://files.medi-cal.ca.gov/pubsdoco/COVID19_response/COVID19_UninsuredGroupProgram_FAQs.pdf



Frequently Asked Questions (FAQs)

Coronavirus (COVID-19) Uninsured Group

1. What is the Coronavirus (COVID-19) Uninsured Group program?

The COVID-19 Uninsured Group program is a new COVID-19 program that replaces Presumptive Eligibility (PE) for COVID-19. The COVID-19 Uninsured Group program provides temporary, no-cost diagnostic testing, testing-related services and treatment services, including all medically necessary care. This includes associated office, clinic, or emergency room visits related to COVID-19. This program is available to uninsured individuals determined eligible by a Qualified Provider (QP) based on preliminary applicant information.

Questions can also be submitted via email to:

COVID19APPS@dhcs.ca.gov

RHC TELEHEALTH AND NON-RHC DISTANT SITE PROVIDERS

Telehealth services provided to RHC patients by an RHC practitioner are permitted under the Medicare waivers effected during the COVID-19 National Health Emergency; however, an RHC should not bill Medicare for the services of a distant site provider who is not a regular staff RHC practitioner, even though that practitioner may be treating an established RHC patient in the patient's home or at the RHC "Originating Site."

The CMS "Frequently Asked Questions" publication discusses the changes that came into effect for the National Health Emergency, and explains that RHCs may bill for telehealth services of the providers that are currently authorized to furnish primary care services:

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

9. **Question:** Which health care providers are permitted to furnish distant site telehealth services for RHCs and FQHCs during the COVID-19 PHE?
Answer: The health care providers that are currently authorized to furnish primary care services in RHCs and FQHCs are permitted to furnish distant site telehealth services under the waiver authority during the COVID-19 PHE, including physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish telehealth services within their scope of practice and consistent with Medicare benefit rules that apply to all services.

Since the RHC should not bill for non-RHC providers, a related entity, such as a Critical Access Hospital, would be a more appropriate billing entity, using a different organizational NPI than the RHC/FQHC entity.Alternatively, the distant-site practitioner may bill Medicare and other payers to seek reimbursement under a medical group NPI completely independent of the RHC/FQHC.

Furthermore, the cost of distant-site practitioner services must be separated from regular RHC/FQHC provider costs on the cost report, and are not eligible for inclusion in the RHC All-Inclusive Rate (AIR) calculation or the FQHC PPS rate under Medicare:

The cost of distant-site practitioner services must be separated from regular RHC/FQHC provider costs on the cost report.

RHC TELEHEALTH AND NON-RHC DISTANT SITE PROVIDERS

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

MLN Matters Number: SE20016 Revised	Related Change Request (CR) Number: N/A
Article Release Date: July 6, 2020	Effective Date: N/A
Related CR Transmittal Number: N/A	Implementation Date: N/A

Cost Reporting

Costs for furnishing distant site telehealth services will not be used to determine the RHC AIR or the FQHC PPS rate 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".

The definition of an RHC visit and an RHC provider is found in the Medicare Claims Processing Manual, Chapter 9 – RHC/FQHC:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf#

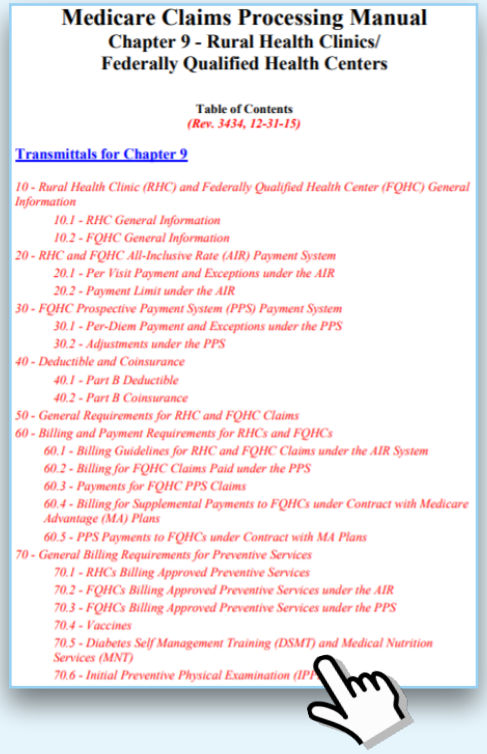
10.1 - RHC General Information

(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs are facilities that provide services that are typically furnished in an outpatient clinic setting. The statutory requirements that RHCs must meet to qualify for the Medicare benefit are in §1861(aa) (2) of the Social Security Act (the Act). A RHC visit is defined as a medically-necessary, face-to-face (one-on-one) medical or mental health visit, or a qualified preventive health visit, with a RHC practitioner during which time one or more RHC services are rendered.

An RHC practitioner is a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW). A Transitional Care Management (TCM) service can also be a RHC visit.

An RHC visit can also be a visit between a homebound patient and an RN or LPN under certain conditions. Until Congress permitted Medicare to exercise flexibility during the COVID-19 National Health Emergency, RHC providers were not permitted to serve as distant-site practitioners. Here's an excerpt from the Medicare Benefits Policy Manual that specifically excludes RHC practitioners from serving and distant site telehealth practitioners:



Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/
Federally Qualified Health Centers

Table of Contents
(Rev. 3434, 12-31-15)

Transmittals for Chapter 9

RHC TELEHEALTH AND NON-RHC DISTANT SITE PROVIDERS

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

200 - Telehealth Services

(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

RHCs and FQHCs may serve as an originating site for telehealth services, which is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. RHCs and FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee.

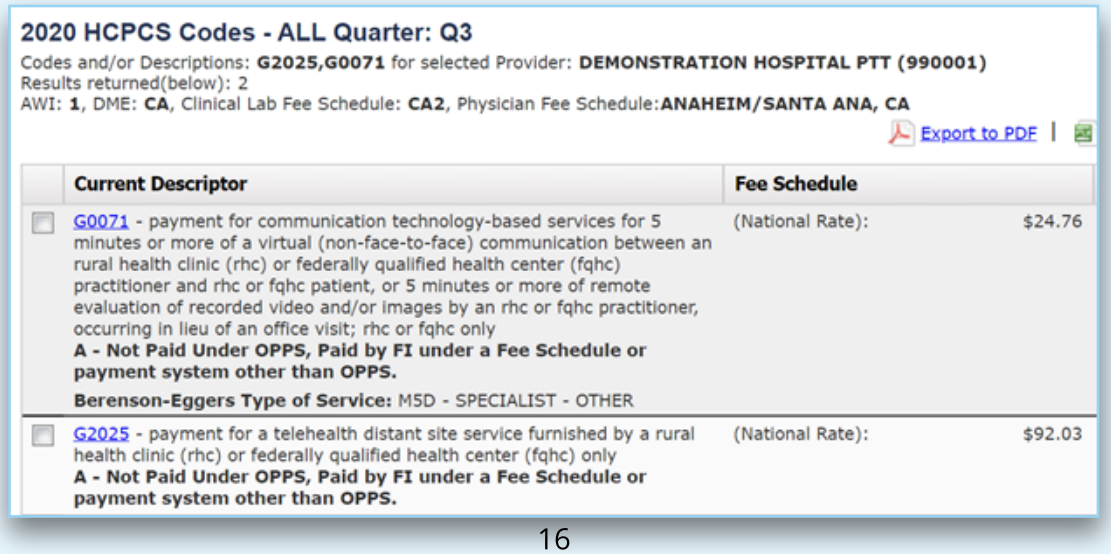
...

RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report.This includes telehealth services that are furnished by an RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract. For more information on Medicare telehealth services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, and Pub. 100-04, Medicare Claims Processing Manual, chapter 12.

In response to the COVID-19 National Health Emergency (NHE), Medicare provided a temporary expansion allowing RHC/FQHC providers to serve as distant site practitioners using its waiver authority, but only while the COVID-19 Public Health Emergency is in effect. The intent was to permit RHC providers to serve patients in their homes over telecommunications technology – thereby reducing the potential spread of COVID-19 to both the patient and the provider/clinic staff.

RHC and FQHC providers report only two different codes for remote services performed by RHC/FQHC providers –

- G2025 for most services on Medicare's telehealth code list; found athttps://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip.G2025 is paid at $92.03 nationally.No modifier is required on an RHC/FQHC claim reporting G2025, since this code is by definition a telehealth code
- G0071 for digital check-ins for RHCs and FQHCs that provide a patient portal.Payment for G0071 is $24.76 nationally.



2020 HCPCS Codes - ALL Quarter: Q3

Codes and/or Descriptions: **G2025,G0071** for selected Provider: **DEMONSTRATION HOSPITAL PTT (990001)**
Results returned(below): 2
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**ANAHEIM/SANTA ANA, CA**

Export to PDF

Current Descriptor	Fee Schedule	
G0071 - payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only **A - Not Paid Under OPPS, Paid by FI under a Fee Schedule or payment system other than OPPS.** **Berenson-Eggers Type of Service:** M5D - SPECIALIST - OTHER	(National Rate):	$24.76
G2025 - payment for a telehealth distant site service furnished by a rural health clinic (rhc) or federally qualified health center (fqhc) only **A - Not Paid Under OPPS, Paid by FI under a Fee Schedule or payment system other than OPPS.**	(National Rate):	$92.03

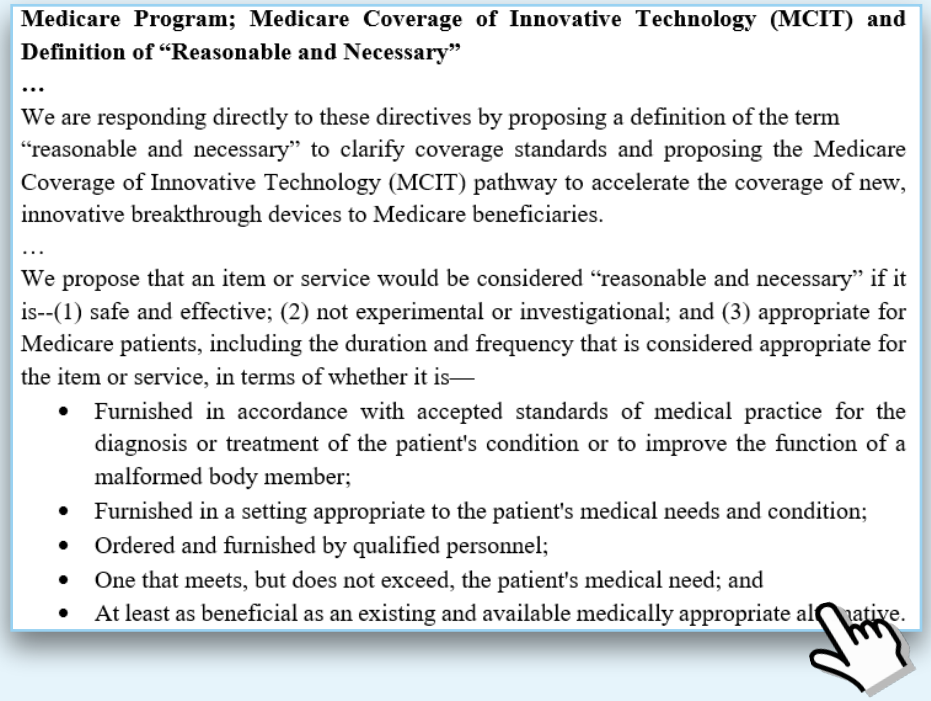
CMS PROPOSES PROMPT COVERAGE FOR "BREAKTHROUGH DEVICES"

SEVERAL months ago, the Office of Management and Budget, which is part of the Office of the President, began considering a policy which would require Medicare and other insurers to provide coverage for the FDA's "Breakthrough Medical Devices" for 3 to four years after receiving FDA approval.The experience during that 3 to 4 years would develop the rationale for continued support, or limitation, of coverage thereafter.

On Monday, August 31, 2020, CMS issued a Proposed Rule that would grant Medicare coverage to "Breakthrough Devices" immediately upon the date of FDA market authorization, rather than waiting for the current National Coverage Determination process, which takes 9 to 12 months.Under the proposed rule, Medicare coverage would be provided for four years after approval from the FDA, and would be consistent nationwide (rather than vary due to Local Coverage Determinations made by MACs.)Devices which received approval in 2019 and 2020 would be eligible for this special treatment.Public comments on the proposed rule will be accepted until November 2, 2020.Typically, CMS will issue a Final Rule 30 to 45 days following the end of the public comment period.

CMS PROPOSES PROMPT COVERAGE FOR "BREAKTHROUGH DEVICES"

https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-19289.pdf



Medicare Program; Medicare Coverage of Innovative Technology (MCIT) and Definition of "Reasonable and Necessary"

…

We are responding directly to these directives by proposing a definition of the term "reasonable and necessary" to clarify coverage standards and proposing the Medicare Coverage of Innovative Technology (MCIT) pathway to accelerate the coverage of new, innovative breakthrough devices to Medicare beneficiaries.

…

We propose that an item or service would be considered "reasonable and necessary" if it is--(1) safe and effective; (2) not experimental or investigational; and (3) appropriate for Medicare patients, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is—

- Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
- Furnished in a setting appropriate to the patient's medical needs and condition;
- Ordered and furnished by qualified personnel;
- One that meets, but does not exceed, the patient's medical need; and
- At least as beneficial as an existing and available medically appropriate al[illegible]ative.

The FDA's Breakthrough Medical Devices program is intended to expedite the development and prioritize the review of certain medical devices that provide for more effective treatment or diagnosis of life-threatening or irreversibly debilitating diseases or conditions.

The Breakthrough Devices Program is for medical devices and device-led combination products that meet two criteria:

1. The device provides for more effective treatment or diagnosis of life-threatening or irreversibly debilitating human disease or conditions

2. The device must satisfy one of the following elements: it represents a breakthrough technology; no approved or cleared alternatives exist; it offers significant advantages over existing approved or cleared alternatives, including additional considerations outlined in the statute; or device availability is in the best interest of patients

At the end of the 4-year MCIT pathway, coverage of the breakthrough device would be subject to one of these possible outcomes:

- NCD (affirmative coverage, which may include facility or patient criteria);
- NCD (non-coverage); or
- MAC discretion (claim-by-claim adjudication or LCD)

CMS proposes that reimbursement for MCIT devices would follow the current reimbursement processes for New Technology.

- Under the Inpatient Prospective Payment System, the amount of additional reimbursement, above the DRG varies depending on the hospital's cost to charge ratio and the DRG reimbursement.At most, the add-on would be one-half the cost of the MCIT device (for full details, see section 160 of Chapter 3 of the Medicare Claims Processing Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf#.)
- Under the Outpatient Prospective Payment System, HCPCS for New Technology items are paid under OPPS as pass-through status G, which utilizes the hospital's cost-to-charge ratio applied to billed charges in calculating reimbursement.

APPROPRIATE USE PROGRAM TEST AND EDUCATE PERIOD EXTENDED

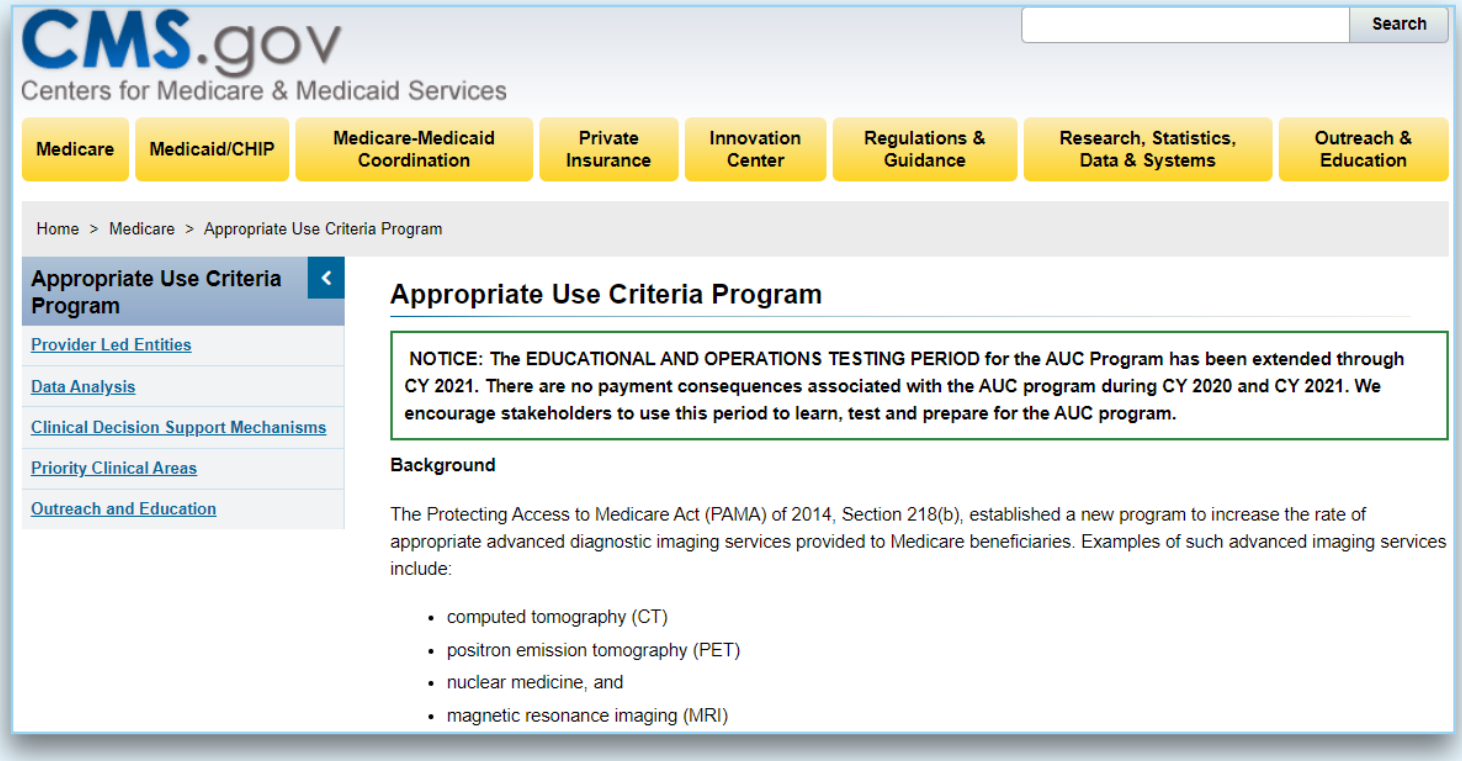
The 2021 OPPS Proposed Rule published in early August, 2020 was silent as to the status of the Appropriate Use Criteria program.

Last year, CMS announced that calendar year 2020 would serve as a "test and educate" period during which certain providers billing for advanced imaging studies are required to report, using informational G-codes, whether the ordering physician consulted a "clinical decision support mechanism."The requirement to report the informational codes is currently in effect, but Medicare will not yet impose penalties for failure to report, or for incorrect reporting.

On August 11, 2020, Medicare quietly added a notice to its Appropriate Use Criteria Program webpage, announcing that the "educational and testing period" has been extended through calendar year 2021:

"NOTICE: The EDUCATIONAL AND OPERATIONS TESTING PERIOD for the AUC Program has been extended through CY 2021. There are no payment consequences associated with the AUC program during CY 2020 and CY 2021. We encourage stakeholders to use this period to learn, test and prepare for the AUC program."

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program



HOME HEALTH: BILLING OSTEOPOROSIS DRUGS

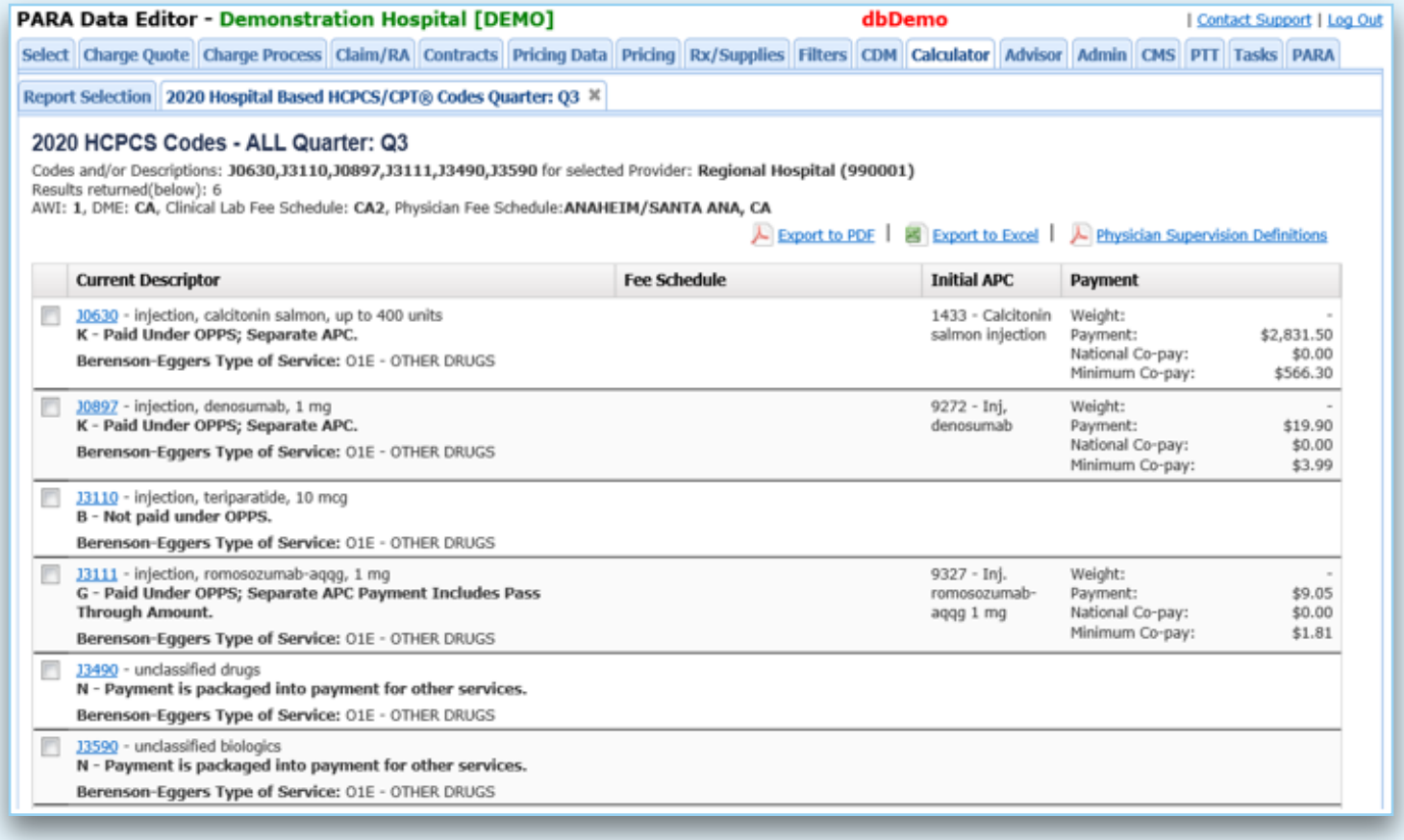
In Home Health, consolidated billing rules require the primary home health agency (HHA) to bill osteoporosis drugs for beneficiaries meeting the coverage requirements for these drugs, if the patient is under a certified HHA-PPS episode.

The actual Osteoporosis drug (s) are excluded from reimbursement under the Home Health Prospective Payment System (HHA-PPS) and are instead reimbursed to providers on a reasonable cost basis.

Reimbursement for administering the drug is included in the HH-PPS episode payment. The primary HHA should submit these charges with other skilled nursing visits on the HH-PPS claim using type of bill (TOB) 329, along with all other applicable home health related services provided by the HHA during the episode.

Providers seeking reimbursement for this service should:

- Ensure the beneficiary is entitled to Medicare Part B
- The date of service for the covered osteoporosis drug(s) must fall within the start and end-dates of an existing HHA PPS episode
- The provider number on the claim for osteoporosis drug(s) must also match the provider number that established the home health episode during which the drug(s) were administered. Of note: HHAs should be aware if Medicare denies the skilled nursing visit during which the osteoporosis drug was administered, the charges for the drug will not be paid as well by Medicare.



HOME HEALTH: BILLING OSTEOPOROSIS DRUGS

In addition to the usual information that is required on an HHA -PPS Medicare claim, the following table will identify the specific data that is required for osteoporosis drug(s) reporting:

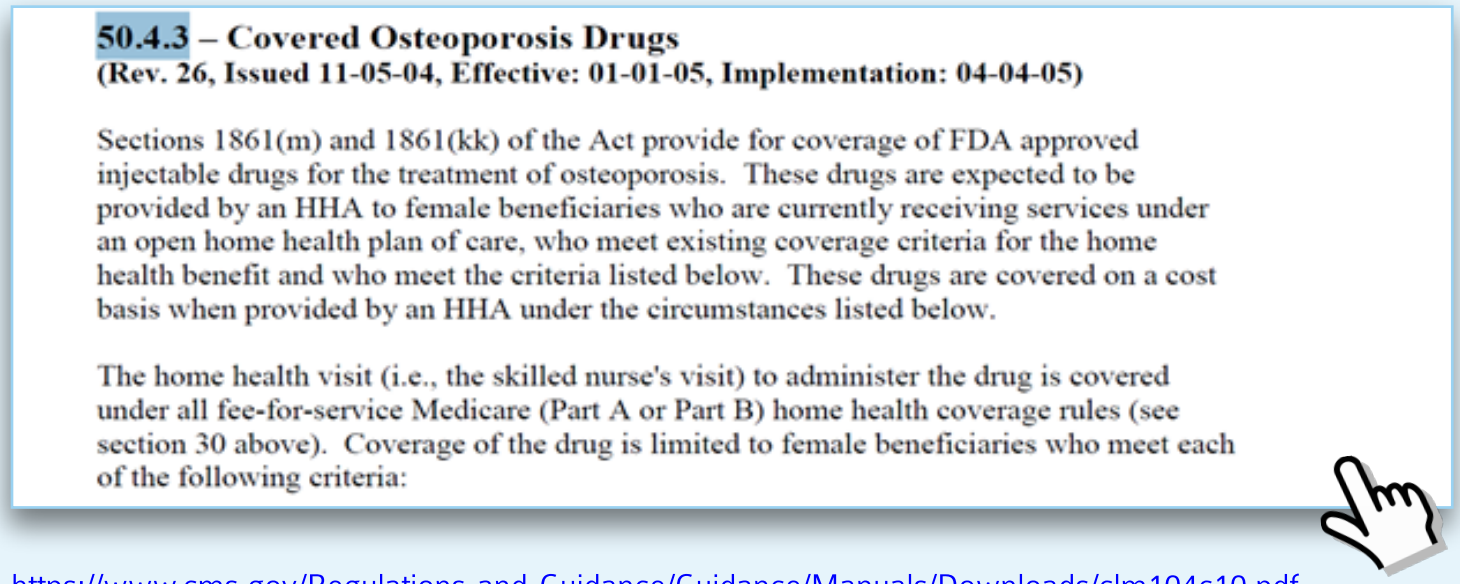
Field Name	Description
Type of bill (TOB)	34X – HHA visit(s) provided on an outpatient basis
Statement dates from/To	Enter the dates of service for the billing period. NOTE: these dates should fall within the "FROM" and "TO" dates for the HH-PPS episode of care being provided by the primary HHA
Revenue Code	Enter the revenue code 0636 - Pharmacy
HCPCS	Enter the appropriate HCPCS code: J0630 – Drugs containing calcitonin J3110 – Drugs containing teriparatide (Forteo) J0897 - Drugs containing denosumab (Xgeva, Prolia) J3111 - Drugs containing romosozumab-aqqg (Evenity) J3490 – Drugs that are FDA approved and awaiting a specific HCPCS assignment J3590 - Drugs that are FDA approved and awaiting a specific HCPCS assignment (Tymlos)
Total Unit/Covered Unit	Enter units as defined by HCPCS code: **J0630** – 1 unit for every 100-400 units furnished during billing period 2 units for every 401-800 units furnished during billing period 3 units for every 801 -1200 units furnished during billing period 4 units for every 1201 -1600 units furnished during billing period 5 units for every 1601 -2000 units furnished during billing period 6 units for every 2001- 2400 units furnished during billing period **J3110** – Report 1 units for every 10mcg furnished during billing period J0897 - Report 1 unit for each 1mg dose provided during the billing period J3111 – Report 1 unit for each 1mg does provided during the billing period **J3490** – Report units as defined by the HCPCS code
Total Charges	Enter the charge per revenue code for the osteoporosis drug
Service date	Enter the line item **date of service** the drug was provided
Diagnosis Codes	Enter the ICD-9 code 733.01 (for DOS on or before October 01, 2015), or the ICD-10 code M810 (for DOS on or after October 01, 2015)

HOME HEALTH: BILLING OSTEOPOROSIS DRUGS

References for this article:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

Chapter 7, Section 50.4.3



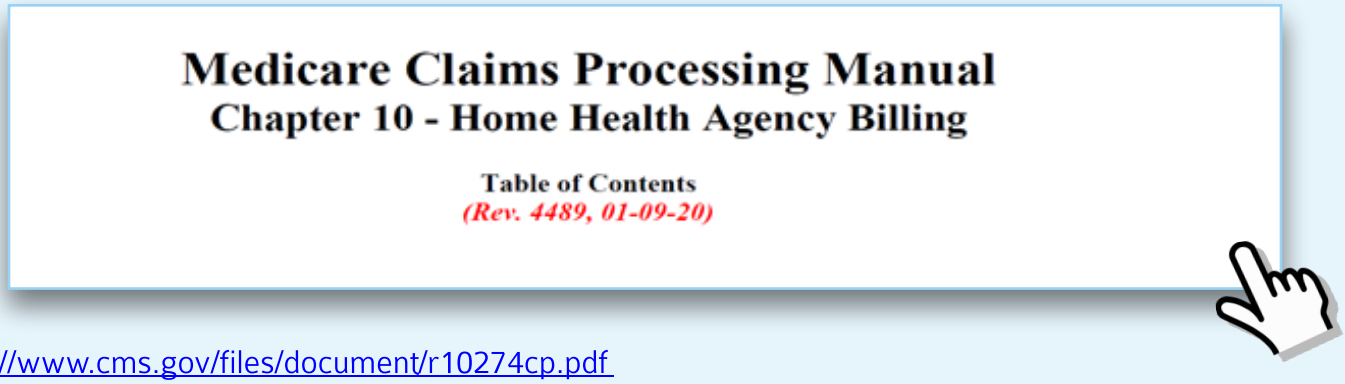
50.4.3 – Covered Osteoporosis Drugs
(Rev. 26, Issued 11-05-04, Effective: 01-01-05, Implementation: 04-04-05)

Sections 1861(m) and 1861(kk) of the Act provide for coverage of FDA approved injectable drugs for the treatment of osteoporosis. These drugs are expected to be provided by an HHA to female beneficiaries who are currently receiving services under an open home health plan of care, who meet existing coverage criteria for the home health benefit and who meet the criteria listed below. These drugs are covered on a cost basis when provided by an HHA under the circumstances listed below.

The home health visit (i.e., the skilled nurse's visit) to administer the drug is covered under all fee-for-service Medicare (Part A or Part B) home health coverage rules (see section 30 above). Coverage of the drug is limited to female beneficiaries who meet each of the following criteria:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf

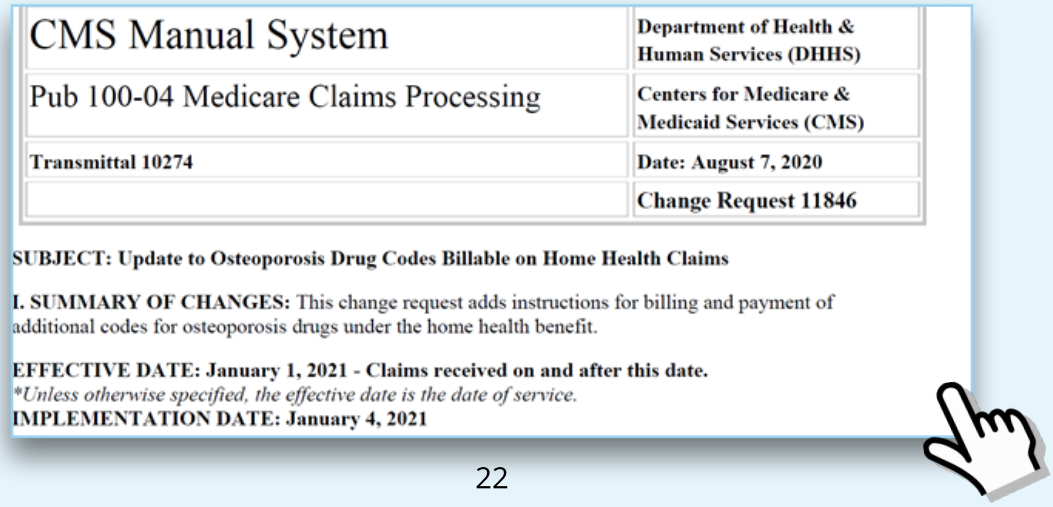
Chapter 10 Sections: 10, 20 and 90.1



Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents
(Rev. 4489, 01-09-20)

https://www.cms.gov/files/document/r10274cp.pdf



CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10274	**Date: August 7, 2020**
	Change Request 11846

SUBJECT: Update to Osteoporosis Drug Codes Billable on Home Health Claims

I. SUMMARY OF CHANGES: This change request adds instructions for billing and payment of additional codes for osteoporosis drugs under the home health benefit.

EFFECTIVE DATE: January 1, 2021 - Claims received on and after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

OTA AND COTA DESIGNATIONS

What are the distinctions between an OTA and a COTA?

Definition of an OTA vs a COTA: An OTA or COTA is the assistant to an Occupational Therapist. The C stands for certified and means the OTA has taken the additional steps in education in addition to holding their state license as an OTA. The OTA has become certified by the National Board of Certified Occupational Therapists (NBCOT).

This C distinction is similar to how an Occupational Therapist, or OT, is also recognized by OTR/L, indicating the therapist is Registered (R) and Licensed (L)."

OTAs are educated at an accredited OTA program and then take the necessary steps to obtain their state OTA license. A COTA professional takes one additional education step to obtain the NBCOT certification.

Where an OTA/COTA may work: Generally an OTA/COTA can be found working in:

- Hospitals
- Nursing care facilities
- Patient's homes
- Schools K-12
- OT/PT Clinics
- Traveling OTAs/COTAs who service patients all over an assigned territory at various locations

The reason OTAs work in these places is that their patients are generally pediatric, geriatric, or someone with a debilitating health condition that requires day to day assistance.

What does an OTA/COTA do? An OTA/COTA works with the young, old, or disabled to assist them through their day to day activities. They perform activities or "occupations" with their patients to help them maintain, develop, and progress fine motor skills or mental skills that the patient is lacking for any number of medical reasons. These reasons or problems may be physical, mental, developmental, or emotional depending on the work setting and specialization of the OTA/COTA.

Common OT activities or "occupations" that could be performed as part of a treatment plan by an OTA/COTA:

- Assisting disabled children to fully participate socially and in their education at school
- Assisting trauma or injury victim's recovery by regaining their cognitive ability and other life skills
- Assisting elderly that are experiencing various mental, physical, and various cognitive disabilities such as Alzheimer's and Dementia
- Evaluating a variety of unique patients and their families to help determine a plan with goals for Occupational Therapy Interventions
- Implementation of their individual therapy plans to assist the patient to improve their ability to perform their daily activities and meet the suggested goals
- Monitoring the outcomes and making adjustments to the therapy plan as needed to ensure suggest goals are met

OTA AND COTA DESIGNATIONS

Reimbursement of an OTA vs COTA: Currently in proposal (Bipartisan Budget Act 2018 (BBA2018) is a large bill that contains proposals to change the way services provided by an OTA/COTA are paid under Medicare Part B. The same proposals are applied to a physical therapy assistant (PTA) payment.

In this proposal, there is a long list of "offsets", or ways to pay for increases for rural health, hospitals, ambulance services, and other programs like federal health centers. Among this long list of "offsets" are cuts to the home health payment system, which will also have an impact on occupational therapy.

In the first of two parts to the proposal, it requires that all occupational therapy or physical therapy claims indicate whether the provider was an OT or OTA, or PT or PTA, beginning in FY 2020. The modifiers that were established by CMS are CO and CQ.

In the second part, providers will see language that proposes to reduce payments for OTAs and PTAs for services provided under the Medicare Physician Fee Schedule (MPFS) to 85% or what is paid for services provided by a therapist (OT and PT) in FY 2022. This proposed reimbursement change will align to the current reimbursement for physician assistants (PAs) and nurse practitioners (NPs) which are reimbursed at 85% of what physicians are reimbursed.

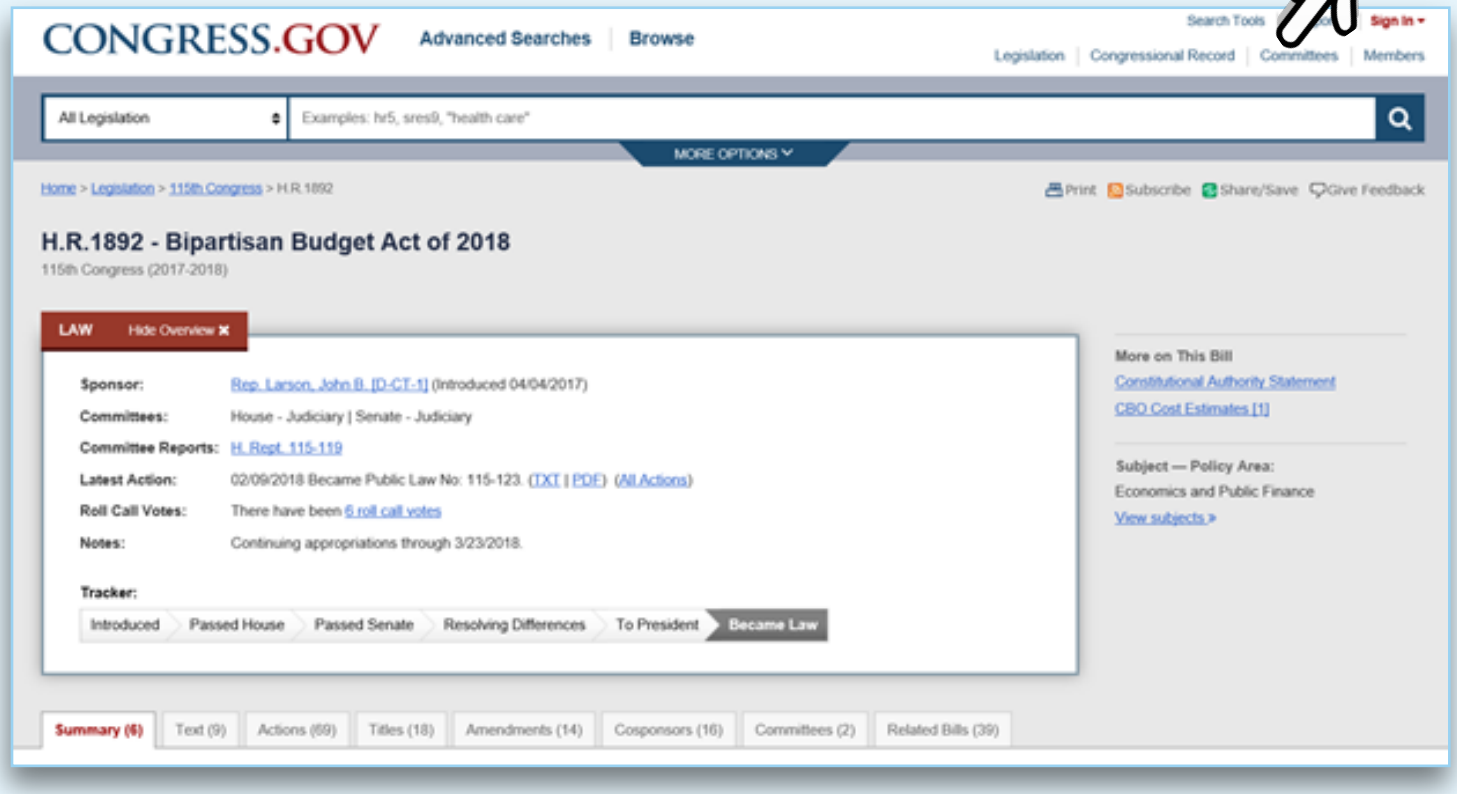
Beginning in CY 2022, therapy services provided by an OTA/COTA will be reimbursed at 85% of the typical payment rate. However,this change does not impact when services are rendered in the following settings:

- Part A Skilled Nursing Facility (SNF) stays
- Home Health
- Hospice
- Inpatient rehabilitation hospitals
- Other certified Medicare providers covered under Part A

OTA AND COTA DESIGNATIONS

Reference:

https://www.congress.gov/bill/115th-congress/house-bill/1892



TITLE XI—PROTECTING SENIORS' ACCESS TO MEDICARE ACT

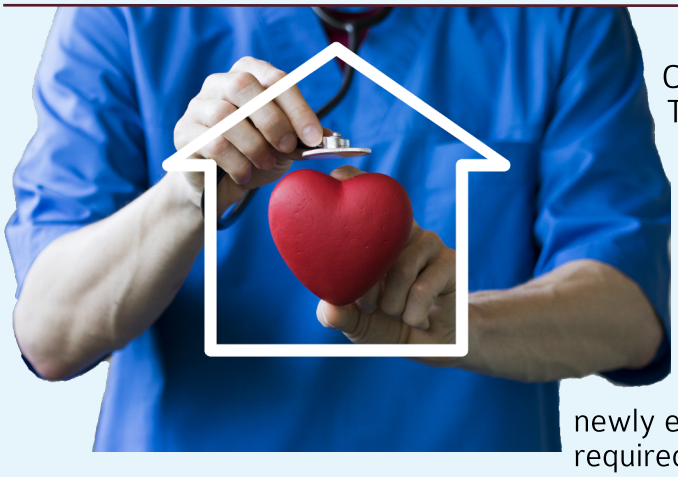
Sec. 52001. Repeal of the Independent Payment Advisory Board.

TITLE XII—OFFSETS

Sec. 53101. Modifying reductions in Medicaid DSH allotments.
Sec. 53102. Third party liability in Medicaid and CHIP.
Sec. 53103. Treatment of lottery winnings and other lump-sum income for purposes of income eligibility under Medicaid.
Sec. 53104. Rebate obligation with respect to line extension drugs.
Sec. 53105. Medicaid Improvement Fund.
Sec. 53106. Physician fee schedule update.
Sec. 53107. Payment for outpatient physical therapy services and outpatient occupational therapy services furnished by a therapy assistant.
Sec. 53108. Reduction for non-emergency ESRD ambulance transports.
Sec. 53109. Hospital transfer policy for early discharges to hospice care.
Sec. 53110. Medicare payment update for home health services.
Sec. 53111. Medicare payment update for skilled nursing facilities.
Sec. 53112. Preventing the artificial inflation of star ratings after the consolidation of Medicare Advantage plans offered by the same organization.
Sec. 53113. Sunsetting exclusion of biosimilars from Medicare part D coverage gap discount program.
Sec. 53114. Adjustments to Medicare part B and part D premium subsidies for higher income individuals.
Sec. 53115. Medicare Improvement Fund.
Sec. 53116. Closing the Donut Hole for Seniors.
Sec. 53117. Modernizing child support enforcement fees.
Sec. 53118. Increasing efficiency of prison data reporting.
Sec. 53119. Prevention and Public Health Fund.

NEW HOME HEALTH PENALTY

Home Health Penalty For Delayed Request For Anticipated Payment (RAP) Submission Implementation



CMS recently published MLN Matters Article MM11855. This Transmittal advises Home Health Agency (HHA) providers about the CY 2021 Home Health (HH) Request for Anticipated Payment (RAP) payment policies.

These payment policies will be implemented as of January 01, 2021.

Beginning in CY2021, the split-percentage payment will be lowered to zero (0) percent for all HHAs (includes newly enrolled and existing). However, all HHAs would still be required to submit a RAP at the beginning of each 30-day period of care (84FR60548). Since no payment will be associated with the submission of the RAP in CY2021, HHAs are to submit a RAP when:

- The appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented as required in accordance with 4.2 Code of Federal Regulations (CFR) Sections 484.60(b) an 409.43(d); and
- The initial visit within the 60-day certification period has been made and the individual is admitted to HHA care (84 FR 60548)

The information needed for submission of the RAP in CY 2021 will mirror the one-time Notice of Admission (NOA) process, also finalized in the CY 2020 HH PPS Final Rule with comment period, starting CY 2022 (84 FR 60549).

In scenarios where the plan of care dictates multiple 30-day periods of care will be required to effectively treat the beneficiary, HHAs will be allowed to submit RAPs for both the first and second 30-day periods of care (for a 60-day certification) at the same time to help further reduce provider administrative burden (84 FR 60549).

In addition, beginning CY2021, there will be a non-timely submission payment reduction when the HHA does not submit the RAP within 5 calendar days from the start of care date (admission date and from date on the claim will match the start of care) for the first 30-day period of care in a 60-day certification period and within five calendar days of the from date for the second 30-day period of care in the 60-day certification period.

This penalty reduction in payment will be equal to a 1/30th reduction to the wage and case-mix adjusted 30-day period payment amount for each day from the HH start of care date/admission date, or from date for subsequent 30-day period payment amount, including any outlier payment, that the HHA otherwise would have received absent any reduction.

For Low Utilization Payment Adjustment (LUPA) 30-day periods of care in which an HHA fails to submit a timely RAP, no LUPA per-visit payments would be made for visits that occurred on days that fall within the period of care prior to the submission of the RAP. The penalty payment reduction cannot exceed the total payment of the claim. The penalty payment reduction for the late submission of a RAP can be waived for exceptional circumstances as outlined in regulations at 42 CFR 484.205(i)(3).

NEW HOME HEALTH PENALTY

MACs will accept the KX modifier when reported with the Health Insurance Prospective Payment System (HIPPS) code on the revenue code 0023 claim line of Type of Bill (TOB) 032x (except 0322 and 0320) as an indicator that an HHA requests an exception to the late RAP penalty. In addition, the HHA should provide sufficient information in the Remarks section of its claim to allow the MAC to research the exception request. However, if the remarks are not sufficient the MAC will request additional documentation from the HHA.

There are four circumstances that may qualify the HHA for an exception to the consequences of filing the RAP more than five calendar days after the HH period of care "From" date:

- Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate
- An event that produces a data filing problem due to a CMS or MAC systems issue that is beyond the control of the HHA
- A newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC
- Other circumstances determined by the MAC or CMS to be beyond the control of the HHA

Other items of note from this Transmittal update are:

- Value codes 61 and 85 are optional for RAPs with "From" dates on and after January 01, 2021

61 Place of Residence Where Service Is Furnished (HHA and Hospice)

This code indicates the MSA or CBSA number (or rural state code) of the place of residence where the home health or hospice service is delivered. Effective July 1, 2018, this field should be left-justified.

- This code is **required for Medicare** home health and hospice billing, when applicable.
- Home health episode payments are based upon the site at which the beneficiary is served. RAPs and claims will not be processed without this value code. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 10, sec. 40.2)
- Enter the MSA or CBSA number where care is being rendered, not the agency location.
- Hospices must report value code 61 when RC 0651 or 0652 is reported in FL 42. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 11, sec. 30)
- When home hospice services are provided in more than one CBSA during the billing period, report the CBSA that applies at the end of the billing period. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 11, sec. 30.3)

85 County where Service is Rendered (effective January 1, 2019)

Report the Federal Information Processing Standards (FIPS) state and county codes when required by law or regulation. There should be no space between the state and county code.

- Other Diagnosis Codes are optional for RAPs with "From" dates on and after January 01, 2021

NEW HOME HEALTH PENALTY

Reference for this article can be found at:

https://www.cms.gov/files/document/r10254cp.pdf

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10254	**Date: July 31,2020**
	Change Request 11855

SUBJECT: Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation

I. SUMMARY OF CHANGES: This Change Request implements the calendar year 2021 home health RAP payment policies.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

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

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

https://www.cms.gov/files/document/mm11855.pdf

Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation

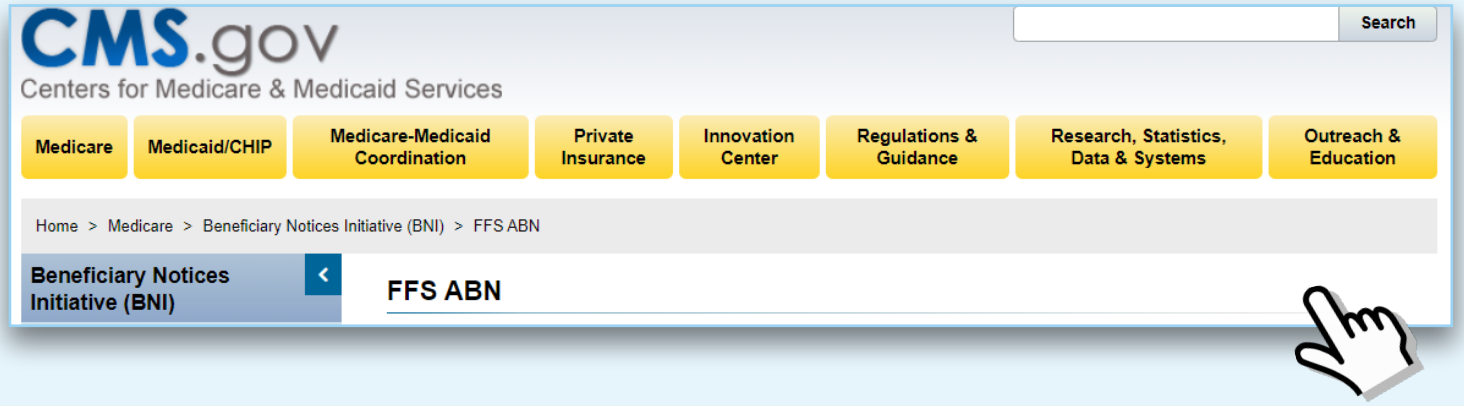
MLN Matters Number: MM11855
Related Change Request (CR) Number: 11855
Related CR Release Date: July 31, 2020
Effective Date: January 1, 2021
Related CR Transmittal Number: R10254CP
Implementation Date: January 4, 2021

CMS DELAYS DEADLINE FOR MANDATORY USE OF REVISED ABN

CMS is delaying use of Advance Beneficiary Notice (ABN) Form, CMS-R-131 due to COVID-19 concerns. The form may be implemented prior to the mandatory deadline, but CMS has extended the deadline from August 31, 2020 to January 1, 2021. The expiration date of the new form is 06/30/2023.

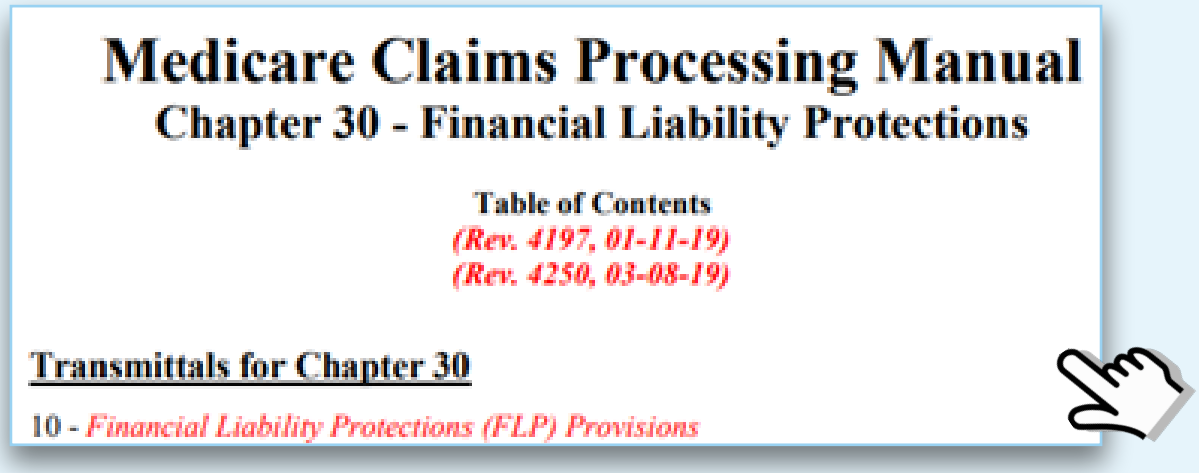
The updated ABN form, in both PDF and Microsoft Word versions with instructions in English and Spanish are available for download using the link below:

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



Chapter 30 of the Medicare Claims Processing Manual beginning Section 50.3 provides information and instructions on the requirements of completing and issuing an Advance Beneficiary Notice:

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



Providers must issue an ABN when a service to a Medicare beneficiary is expected to be denied.Medicare lists three "triggering events" when ABNs are appropriate.

- **Initiations:** Noncovered or non reasonable and necessary services beginning a new treatment
- **Reductions:** Medicare has determined a reduction in frequency of treatment is appropriate, but beneficiary chooses to continue with care at same rate or frequency higher than approved by Medicare, knowing that the care is no longer considered medically reasonable and necessary
- **Terminations:** The beneficiary wants to continue with no longer medically reasonable and necessary services after meeting treatment goals

CMS DELAYS DEADLINE FOR MANDATORY USE OF REVISED ABN

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the D._____listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

CMS DELAYS DEADLINE FOR MANDATORY USE OF REVISED ABN

A. Notificante:

B. Nombre del paciente: **C. Número de Identificación:**

Aviso anticipado de no cobertura al beneficiario (ABN, por sus siglas en inglés)

NOTA: Si Medicare no paga por **D.**_____a continuación, usted podría tener que pagar. Medicare no paga por todo, incluidos algunos cuidados que usted o su proveedor de atención médica entienda que son necesarios. Se anticipa que Medicare no pague por **D.**_____a continuación.

D.	E. Motivo por el cual Medicare podría negar el pago:	F. Costo estimado

LO QUE USTED DEBE HACER AHORA:

- Lea este aviso para poder tomar una decisión informada sobre sus cuidados.
- Háganos las preguntas que tenga después de terminar de leer.
- Elija una opción a continuación sobre si recibirá **D.**_____que se indica arriba.
  Nota: Si elige Opción 1 o 2, podríamos ayudarle a utilizar los otros seguros que tenga, pero Medicare no nos puede obligar a hacer esto.

G. OPCIONES: Marque solamente una casilla. No podemos elegir la casilla para usted.

☐ **OPCIÓN 1.** Quiero **D.**_____que se indica arriba. Pudiera pedir el pago ahora, pero yo también solicito que se facture a Medicare para obtener una decisión oficial respecto al pago, la cual me será enviada en un Resumen de Medicare (MSN, por sus siglas en inglés). Entiendo que, si Medicare no paga, yo seré responsable del pago, pero puedo apelar a Medicare según las indicaciones en el MSN. Si Medicare pagará, me serán reembolsados todos los pagos que yo haya hecho, salvo los copagos o deducibles.

☐ **OPCIÓN 2.** Quiero **D.** que se indica arriba, pero no facture a Medicare. Se podrá pedir el pago ahora, ya que yo soy responsable del pago. No podré apelar si no se facturara a Medicare.

☐ **OPCIÓN 3.** No quiero **D.**_____que se indica arriba. Entiendo que, con esta elección, **no** seré responsable del pago, y no podré apelar para saber si Medicare hubiera pagado.

H. Información adicional:

Este aviso explica nuestra opinión y no constituye una decisión oficial de Medicare. Si usted tiene otras preguntas relativas a este aviso o la facturación de Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Firme abajo para reconocer haber recibido y entendido este aviso. Usted también recibirá una copia.

I. Firma:	J. Fecha:

CMS no discrimina en sus programas y actividades. Para solicitar esta publicación en formato alternativo, llame al: 1-800-MEDICARE o envíe un mensaje de correo electrónico: AltFormatRequest@cms.hhs.gov.

De acuerdo con la Ley para la Reducción de Trámites de 1995, ninguna persona será obligada a responder a una recopilación de información a menos que se exhiba un número de control válido de la OMB. El número de control válido de la OMB para esta recopilación de información es 0938-0566. El tiempo necesario para completar esta recopilación de información es de aproximadamente 7 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar fuentes de datos existentes, reunir los datos necesarios, y completar y revisar la recopilación de información. Si tiene preguntas sobre la precisión del estimado de tiempo o sugerencias para mejorar este formulario, escriba a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

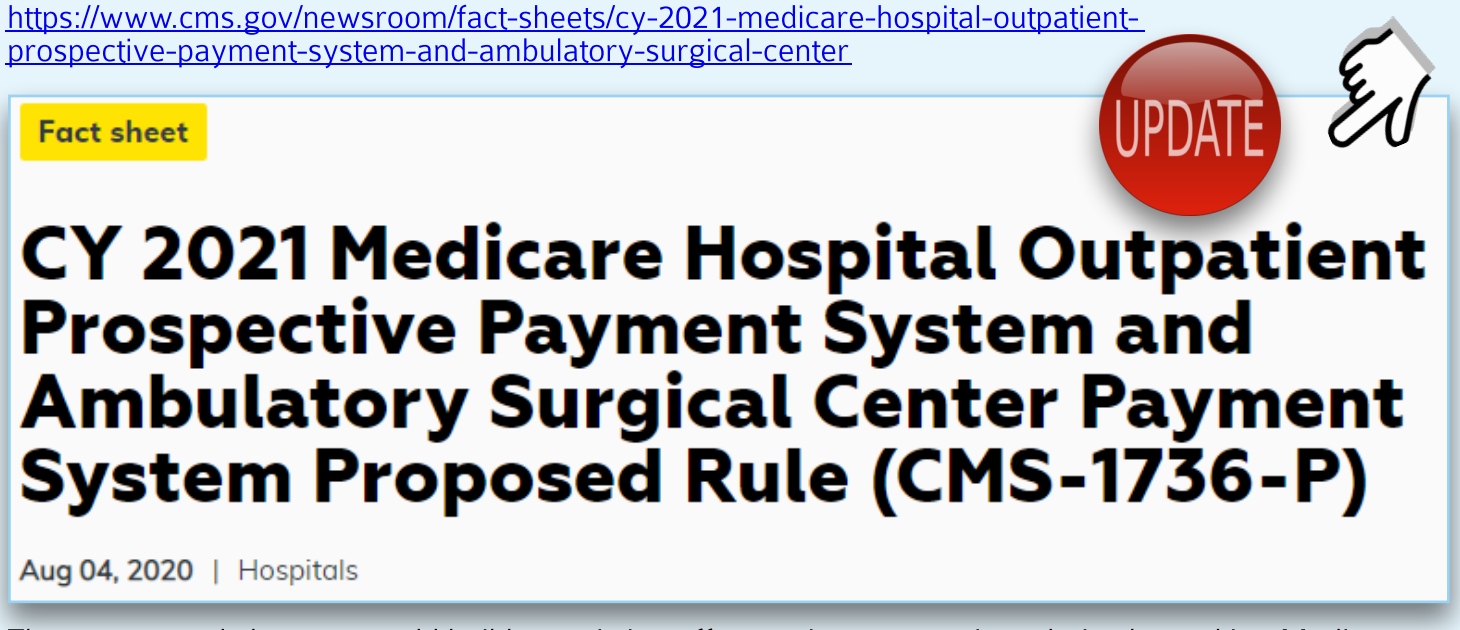
Formulario CMS-R-131 (Exp. 06/30/2023) Formulario aprobado OMB No. 0938-0566

CY2021 MEDICARE OPPS AND ASC PROPOSED RULE (CMS-1736-P)

On August 4, 2020, the Centers for Medicare & Medicaid Services (CMS) proposed policies that are consistent with the directives in President Trump's Executive Order, entitled "Protecting and Improving Medicare for Our Nation's Seniors," that aims to increase choice, lower patients' out-of-pocket costs, empower patients, and protect taxpayer dollars.

Much of the fact sheet follows and can also be reached at the following link

https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center



These proposed changes would build on existing efforts to increase patient choice by making Medicare payment available for more services in different sites of service and adopting policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

The CY 2021 OPPS/ASC Payment System proposed rule would further advance the agency's commitment to strengthening Medicare and reducing provider burden so that hospitals and ambulatory surgical centers can operate with increased flexibility, and patients are better equipped to be active healthcare consumers.

Increasing Choice and Encouraging Site Neutrality

The proposed rule includes policies that would continue to give beneficiaries more affordable choices on where to obtain care with the potential for lower out-of-pocket expenses.

Proposed Elimination of the Inpatient Only List

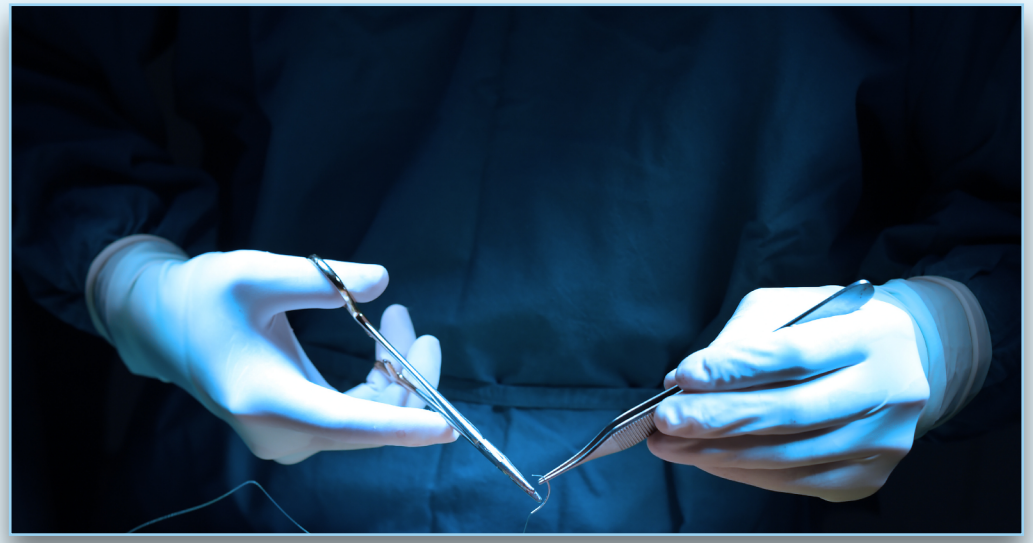
In this rule, we propose to eliminate the Inpatient Only (IPO) list over a three-year transitional period with the list completely phased out by CY 2024. We propose to begin with the removal of nearly 300 musculoskeletal-related services, which would make these procedures eligible to be paid by Medicare in the hospital outpatient setting when outpatient care is appropriate in addition to the existing ability for payment in the hospital inpatient setting when inpatient care is appropriate, as determined by the physician. We also solicit comment on several related issues including whether three years is an appropriate time frame for transitioning to eliminate the IPO list, whether there are other services that are candidates for removal from the IPO list for CY 2021, and how we should sequence the removal of additional clinical families and/or specific services from the IPO list in future rulemaking.

CY2021 MEDICARE OPPS AND ASC PROPOSED RULE (CMS-1736-P)

Additionally, procedures removed from the IPO list will eventually become subject to the 2-midnight rule. In the CY 2020 OPPS/ASC final rule, CMS finalized a two-year exemption from certain medical review activities related to the 2-midnight rule for procedures newly removed from the IPO list. In this rule, we propose to continue the two-year exemption from certain medical review activities relating to patient status for procedures removed from the IPO list beginning in CY 2020 and subsequent years. We solicit comment on whether the 2-year period is appropriate, or whether a longer or shorter exemption period would be more appropriate.

Under this policy, Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO) reviews of short-stay inpatient claims for procedures that have been removed from the IPO list within the first two years would be eligible to be reviewed for medical necessity of the underlying services and to educate providers and practitioners regarding compliance with the 2-midnight rule. However, claims would not be denied based on patient status (that is, site of service) alone.

Furthermore, these procedures would not be eligible for referral to the Recovery Audit Contractors (RAC) for noncompliance with the 2-midnight rule for a two-year period after their removal from the IPO list. This two-year exemption period would allow providers time to update their billing systems and gain experience with respect to newly removed procedures from the IPO list, while avoiding potential adverse site of service determinations.



ASC Covered Procedures List

CMS is proposing to expand the number of procedures that Medicare would pay for when performed in an ASC, which would give patients more choice on where to receive care and ensure CMS payment policies do not favor one type of care setting over another.

For CY 2021, we propose to add eleven procedures to the ASC covered procedures list (CPL), including total hip arthroplasty (CPT 27130). Additionally, we are proposing two alternatives to further expand services payable in ASCs that would give beneficiaries more choices on where to get care. Under the first alternative, we propose to modify certain criteria for adding a procedure to the ASC-CPL and to establish a nomination process under which external stakeholders, such as professional specialty societies, would use suggested parameters to nominate procedures that can be safely performed in the ASC setting.

CMS would select nominated procedures to propose and finalize adding to the ASC CPL through annual rulemaking.Under the other alternative proposal, we would revise the ASC CPL criteria under 42 CFR 416.166, keeping the general standard criteria (i.e., the procedure would not be expected to pose a significant safety risk to a beneficiary when performed in an ASC or to require active medical monitoring and care at midnight following the procedure) and eliminating five general exclusion criteria. Under the proposed revised regulations, we would add approximately 270 potential surgery or surgery-like procedures to the ASC-CPL that are not on the CY 2020 IPO list and that meet the revised regulatory criteria Additionally, under this alternative proposal, we solicit comment on whether the conditions for coverage for ASCs (the baseline health and safety requirements for Medicare-participating ASCs) should be revised given the nature of the services that would be added under this alternative.

CY2021 MEDICARE OPPS AND ASC PROPOSED RULE (CMS-1736-P)

When receiving care in an ASC rather than a hospital outpatient department, patients can potentially lower their out-of-pocket costs for certain services. For example, for one of the most common cataract surgeries, currently, on average, a Medicare beneficiary pays $101 if the procedure is done in a hospital outpatient department compared to $51 if done in a surgery center. Since 2018, CMS has added 28 procedures to the ASC-CPL.

CY 2021 OPPS Payment Methodology for 340B Purchased Drugs

Section 340B of the Public Health Service Act (340B)allows participating hospitals and other providers to purchase certain covered outpatient drugs from manufacturers at discounted prices. In the CY 2018 OPPS/ASC final rule, CMS reexamined the appropriateness of the prior Average Sale Price (ASP) plus 6 percent payment methodology for drugs acquired through the 340B Program, given that 340B hospitals acquire these drugs at steep discounts.

Beginning January 1, 2018, Medicare adopted a policy to pay an adjusted amount of ASP minus 22.5 percent for certain separately payable drugs or biologicals acquired through the 340B Program that had been subject to ongoing litigation and was upheld by the D.C Circuit Court on July 31, 2020.

In this rule, we are proposing to adopt a rate of ASP-34.7 percent with a 6 percent add-on amount for overhead and handling costs for a net proposed rate of ASP-28.7 percent for separately payable drugs or biologicals that are acquired through the 340B Program.

We also solicit comment on an alternative proposal of continuing the current Medicare payment policy of paying ASP-22.5 percent for 340B- acquired drugs for CY 2021 and subsequent years. This proposed rate is based on the results of a 340B hospital survey of drug acquisition cost administered earlier this year. Additionally, we are proposing that rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals be excepted from either of the proposed 340B payment policies and that these hospitals would continue to report informational modifier "TB" for 340B-acquired drugs, and continue to be paid ASP+6 percent.

Meaningful Measures/Patients Over Paperwork

CY 2021 Overall Hospital Quality Star Rating for CY 2021 and Subsequent Years. In continuing the agency's efforts to reduce burden and improve efficiencies through the Patients Over Paperwork Initiative, for the first time through the rulemaking process, CMS is proposing to establish, update, and simplify the methodology that would be used to calculate the Overall Hospital Quality Star Rating (Overall Star Rating) beginning with 2021.

After seeking stakeholder input through multiple public venues on the current methodology used to calculate the Overall Star Rating, CMS is proposing to retain certain aspects of the current methodology (e.g., annual refresh, what measures are included, standardization of measure scores, use of k-means clustering to assign a rating) and proposing to update other aspects, such as:

- Combine three existing process measure groups into one new Timely and Effective Care group as a result of measure removals (thus, the Overall Star Rating would be made up of five groups – Mortality, Safety of Care, Readmissions, Patient Experience, and Timely and Effective Care);
- Use a simple average methodology to calculate measure group scores instead of the current statistical Latent Variable Model;
- Stratify the Readmission measure group only by hospitals' proportion of dual-eligible patients to align with Hospital Readmissions Reduction Program (HRRP);
- Change the reporting threshold to receive an Overall Star Rating by requiring a hospital to report at least three measures for three measures groups, however, one of the groups must specifically be the Mortality or Safety of Care group; and

CY2021 MEDICARE OPPS AND ASC PROPOSED RULE (CMS-1736-P)

- Apply peer grouping methodology by number of measure groups where hospitals are grouped by whether they have three or more measures in three, four, or five measure groups (three measure groups is the minimum to receive a rating and five is the proposed number of groups after combining the three process measure groups into one).

These changes, if finalized, will be used to calculate the Overall Star Rating beginning in 2021. Overall, the changes we are proposing aim to:

- Simplify the methodology by reducing the total number of measure groups and create an explicit approach to calculating measure group scores;
- Improve predictability of the Overall Star Rating over time through a simple average of measure scores with equal measure weightings that hospitals can better anticipate; and
- Improve the comparability of the Overall Star Rating through updating the reporting threshold, stratifying the Readmission group, and peer grouping. We are also proposing to include critical access hospitals (CAHs) in the Overall Star Rating as well as Veterans Health Administration (VHA) hospitals.

Hospital Outpatient Quality Reporting (OQR) Program and Ambulatory Surgical Center Quality Reporting (ASCQR) Program:

CMS is proposing changes to update and refine requirements for the Hospital Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) Programs to further meaningful measurement and reporting for quality of care in the outpatient surgical setting while limiting burden. CMS proposes to revise and codify previously finalized administrative procedures and to propose and codify an expanded review and corrections process to further align the Hospital OQR and ASCQR Programs while clarifying program requirements. CMS is not proposing any measure additions or removals for either program.

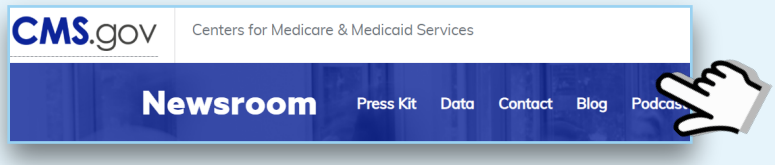
Updates to OPPS Payment Rates:

In accordance with Medicare law, CMS proposes to update OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.6 percent.

This proposed update is based on the projected hospital market basket increase of 3 percent minus a 0.4 percentage point adjustment for multi-factor productivity (MFP).

Get the rest of the new ruling by clicking the link below:

https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center



PRESIDENT TRUMP ADDS NEW DUTIES TO FQHC 340(B) PARTICIPANTS

On July 24, 2020, President Trump issued an executive order that will generate new obligations for Federally Qualified Health Centers (FQHCs) which participate in the Health Resource Services Administration 340(b) pharmacy discount program.

Soon, Medicare will issue new regulations which will require FQHCs to play a new role in supplying insulin and epinephrine kits at greatly reduced cost to uninsured patients and those who struggle to afford their medication even with healthcare coverage.A link and the central content from the order is provided below:

https://www.govinfo.gov/content/pkg/FR-2020-07-29/pdf/2020-16623.pdf

Section 1.

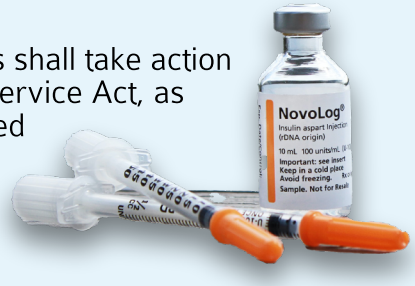
Purpose.Insulin is a critical and life-saving medication that approximately 8 million Americans rely on to manage diabetes. Likewise, injectable epinephrine is a life-saving medication used to stop severe allergic reactions.

... Federally Qualified Health Centers (FQHCs), as defined in section 1905(l)(2)(B)(i) and (ii) of the Social Security Act, as amended, 42 U.S.C. 1396d(l)(2)(B)(i) and (ii), receive discounted prices through the 340B Prescription Drug Program on prescription drugs. Due to the sharp increases in list prices for many insulins and some types of injectable epinephrine in recent years, many of these products may be subject to the ''penny pricing'' policy when distributed to FQHCs, meaning FQHCs may purchase the drug at a price of one penny per unit of measure. These steep discounts, however, are not always passed through to low-income Americans at the point of sale. Those with low-incomes can be exposed to high insulin and injectable epinephrine prices, as they often do not benefit from discounts negotiated by insurers or the Federal or State governments.

Sec. 2. Policy.

It is the policy of the United States to enable Americans without access to affordable insulin and injectable epinephrine through commercial insurance or Federal programs, such as Medicare and Medicaid, to purchase these pharmaceuticals from an FQHC at a price that aligns with the cost at which the FQHC acquired the medication.

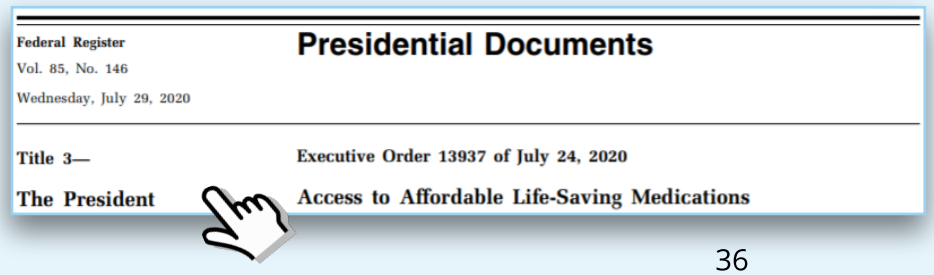
Sec. 3. Improving the Availability of Insulin and Injectable Epinephrine for the Uninsured.



To the extent permitted by law, the Secretary of Health and Human Services shall take action to ensure future grants available under section 330(e) of the Public Health Service Act, as amended, 42 U.S.C. 254b(e), are conditioned upon FQHCs having established practices to make insulin and injectable epinephrine available at the discounted price paid by the FQHC grantee or sub-grantee under the 340B Prescription Drug Program (plus a minimal administration fee) to individuals with low incomes, as determined by the Secretary, who:

- have a high cost sharing requirement for either insulin or injectable epinephrine;
- have a high unmet deductible; or
- have no health care insurance

PARA expects that Medicare will follow the usual rulemaking process, and publish a proposed rule with details of this new obligation. We will provide information about the proposed rule in our weekly journal shortly after more information is published by CMS.

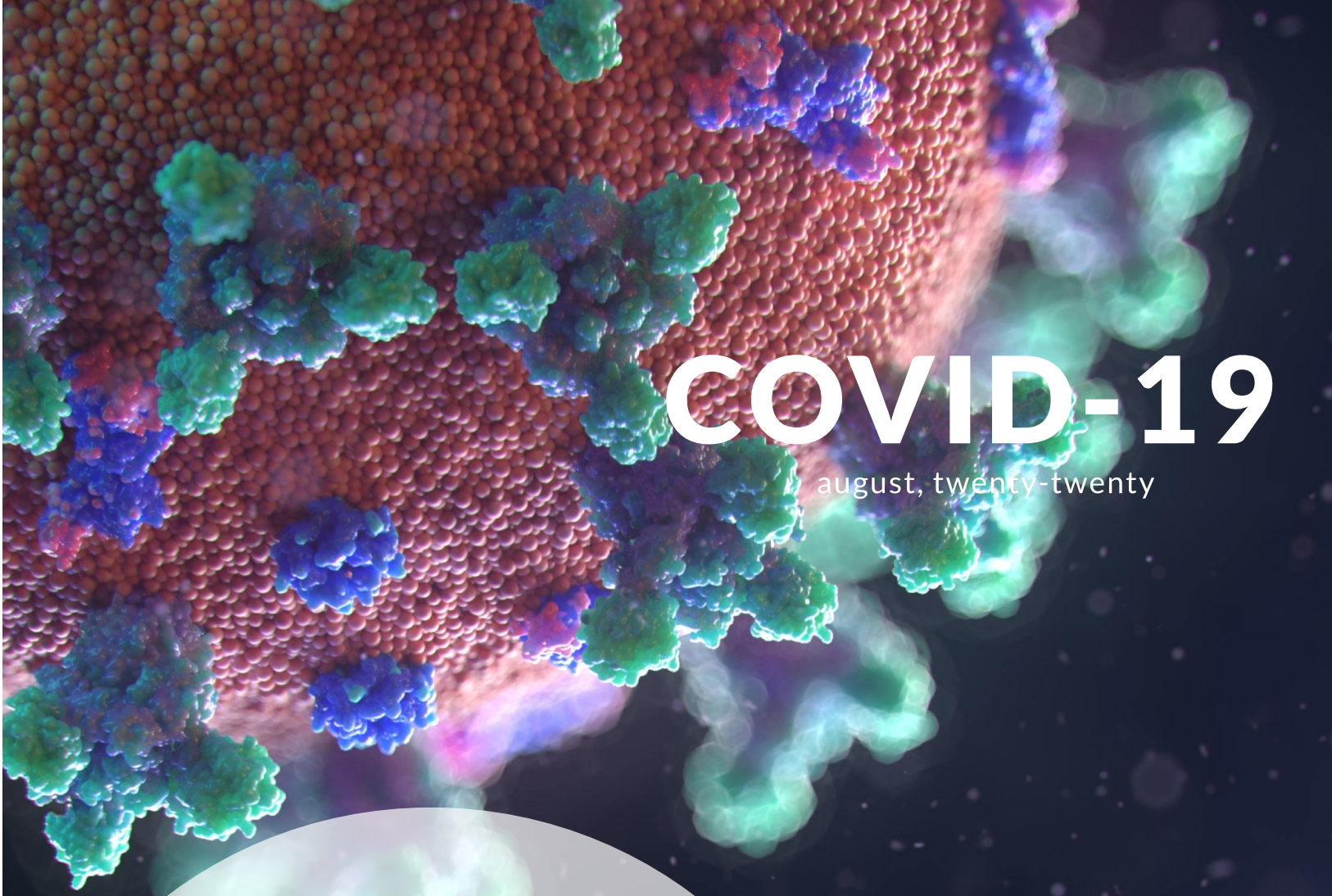

Federal Register
Vol. 85, No. 146
Wednesday, July 29, 2020

Presidential Documents

Title 3—
The President

Executive Order 13937 of July 24, 2020

Access to Affordable Life-Saving Medications



COVID-19

august, twenty-twenty

Special publication

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

This Resource Guide is brought to you by **PARA HealthCare Analytics** and **Healthcare Financial Resources (HFRI)**, the experts answer coding and financial questions.

PARA
HealthCare Analytics

HEALTHCARE
FINANCIAL
RESOURCES

COVID-19 Resource Guide

Coronavirus

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

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

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

Get waiver & flexibility information

General information & updates:

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

Clinical & technical guidance:

For all clinicians

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

For all health care providers

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

For health care facilities

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

COVID-19 Resource Guide

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

For Labs

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

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

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

Billing And Coding Guidance:

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

For Health Care Facilities

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

COVID-19 Resource Guide

Survey And Certification Guidance:

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

Coverage Guidance:

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

Provider Enrollment Guidance:

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

Medicaid & CHIP Guidance:

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

MLN CONNECTS

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

Thursday, August 27, 2020

News

·Trump Administration Launches National Training Program to Strengthen Nursing Home Infection Control Practices

·SNF Provider Preview Reports: Review Your Data by August 30

·COVID: Nursing Home Toolkit

·Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

·COVID-19: Waive Cost Sharing for These HCPCS Codes

MLN Matters® Articles

·Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2021 — Revised

·October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files — Revised

Publications

·Creating an Effective Hospice Plan of Care

Multimedia

·Physician Fee Schedule Listening Session: Audio Recording and Transcript

View this edition as PDF (PDF)

There were FIVE new or revised MedLearns released this week.

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

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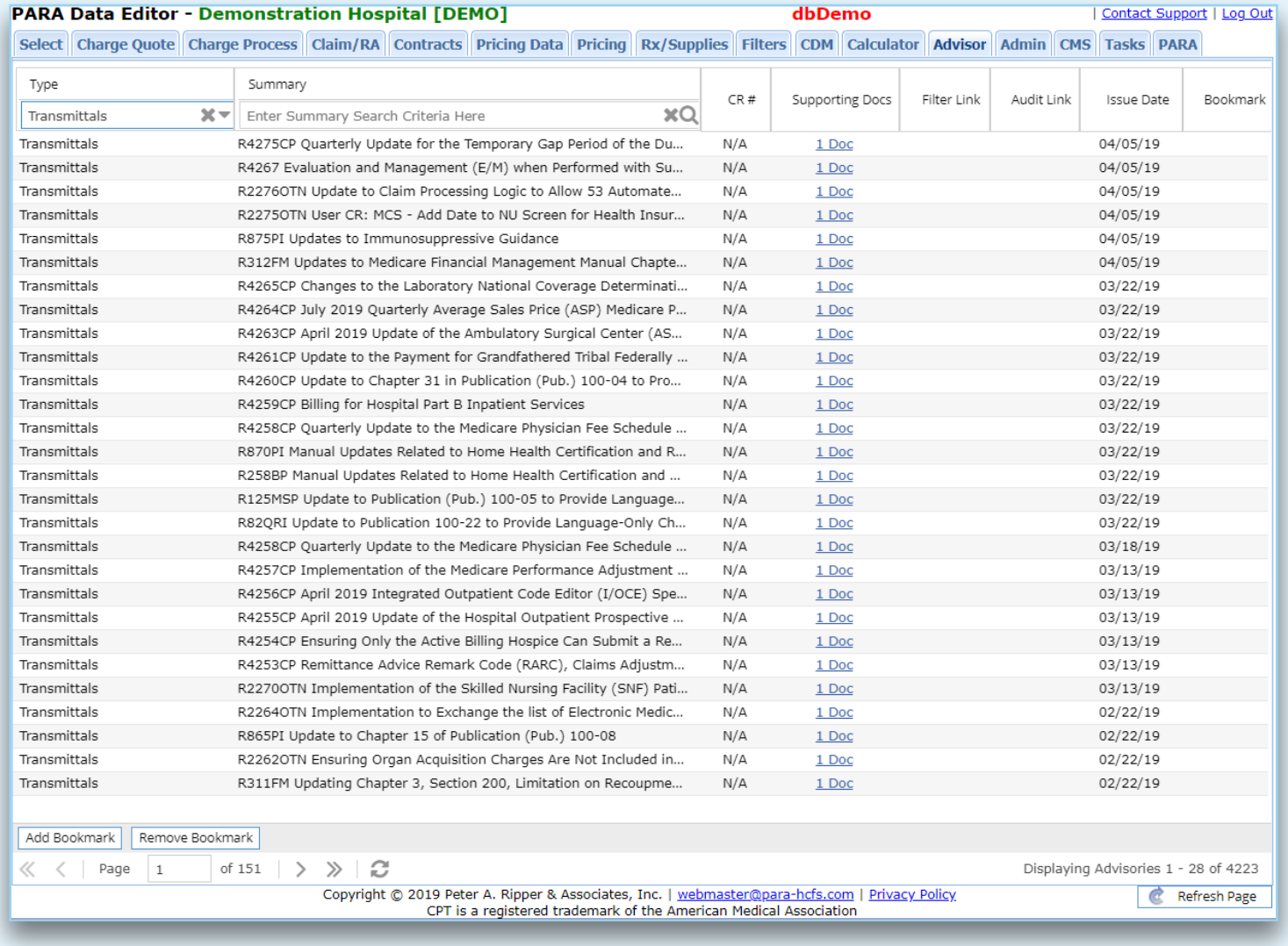

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Page 1 of 151 Displaying Advisories 1 - 28 of 4223

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KNOWLEDGE • RESOURCES • TRAINING

2021 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

MLN Matters Number: MM11852 | Related Change Request (CR) Number: 11852

Related CR Release Date: August 28, 2020 | Effective Date: January 1, 2021

Related CR Transmittal Number: R10323CP | Implementation Date: January 4, 2021

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article informs you that the Centers for Medicare & Medicaid Services (CMS) will provide MACs with files for the automated payments of Health Professional Shortage Area (HPSA) bonuses for dates of service January 1, 2021, through December 31, 2021. Make sure that your billing staffs are aware of these changes.

BACKGROUND

A new automated HPSA bonus payment file is created annually. CR 11852 provides the name of the new file. Section 413(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. The CMS-automated HPSA ZIP code file is populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file will be made available to MACs in early December of each year. MACs will implement the HPSA ZIP code file, and for claims with dates of service January 1 to December 31 of the following year, will make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

MACs will continue to accept the AQ modifier for partially designated HPSA claims.

ADDITIONAL INFORMATION

The official instruction, CR 11852, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10323cp.pdf.

CMS Medicare Learning Network®

The link to this MedLearn MM11944

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KNOWLEDGE • RESOURCES • TRAINING

October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3

MLN Matters Number: MM11944 | Related Change Request (CR) Number: 11944

Related CR Release Date: August 28, 2020 | Effective Date: October 1, 2020

Related CR Transmittal Number: R10332CP | Implementation Date: October 5, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is for hospitals, providers and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article discusses changes to the October 2020 version of the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that Medicare uses

- Under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers and all non-OPPS providers
- For limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System
- For a hospice patient for the treatment of a non-terminal illness.

Make sure your billing staffs are aware of these changes.

BACKGROUND

CR 11944 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for October 1, 2020. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The Centers for Medicare & Medicaid Services (CMS) will post the I/OCE specifications at https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.

The modifications of the I/OCE for the October 2020, v21.3 release, are summarized in the table

CMS Medicare Learning Network®

The link to this MedLearn MM11881

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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

MLN Matters Number: MM11881 | Related Change Request (CR) Number: 11881

Related CR Release Date: August 28, 2020 | Effective Date: January 1, 2021

Related CR Transmittal Number: R10324CP | Implementation Date: January 4, 2021

PROVIDER TYPE AFFECTED

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

PROVIDER ACTION NEEDED

This article informs you that Medicare will update its claims processing systems based on the CORE 360 Uniform use of Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Claim Adjustment Group Code (CAGC) rule publication. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE), Code Combination List, which will be published on or about October 1, 2020. Make sure that your billing staffs are aware of these updates.

BACKGROUND

The DHHS adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, EFT and ERA Operating Rule Set that was implemented on January 1, 2014 under the Patient Protection 45 Code of Federal Regulations (CFR) sections 162.1601 - 162.1603 and Section 1104 of the Affordable Care Act (ACA) of 2010.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act (the Act) by adding Part C—Administrative Simplification—to Title XI of the Act, requiring the Secretary of DHHS (the Secretary) to adopt standards for certain transactions to enable health

CMS Medicare Learning Network

The link to this MedLearn MM11796

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KNOWLEDGE • RESOURCES • TRAINING

Claim Status Category and Claim Status Codes Updates

MLN Matters Number: MM11796 | Related Change Request (CR) Number: 11796

Related CR Release Date: August 28, 2020 | Effective Date: January 1, 2021

Related CR Transmittal Number: R10322CP | Implementation Date: January 4, 2021

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article informs you of updates to the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgement transactions. Please make sure your billing staffs are aware of these updates.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee (NCMC) meets at the beginning of each ASC X12 trimester meeting (January/February; June; and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The NCMC has decided to allow the industry 6 months for implementation of newly added or changed codes.

The code sets are available at https://nex12.org/index.php/codes/17-health-care-claim-status-category and https://nex12.org/index.php/codes/16-health-care-claim-status. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the September/October 2020 NCMC meeting will be posted

CMS Medicare Learning Network®

The link to this MedLearn MM11956

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KNOWLEDGE • RESOURCES • TRAINING

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

MLN Matters Number: MM11956

Related Change Request (CR) Number: 11956

Related CR Release Date: August 28, 2020

Effective Date: October 1, 2020

Related CR Transmittal Number: R10334CP

Implementation Date: October 5, 2020

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

CR 11956 informs DME MACs about the changes to the DMEPOS fee schedules that Medicare updates quarterly, when necessary, to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. Make sure your billing staffs are aware of these changes.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule as required by Sections 1834(a), (h), and (i) of the Social Security Act (the Act). Payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts, and Intraocular Lenses (IOLs) inserted in a physician's office. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts under Section 1834(a)(1)(F) of the Act, as well as codes that are not subject to the fee schedule Competitive Bidding Program (CBP) adjustments.

Fee Schedule Adjustment Methods

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not Competitive Bid Areas (CBAs), based on information from CBPs for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

There were SEVENTEEN new or revised Transmittals released this week.

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

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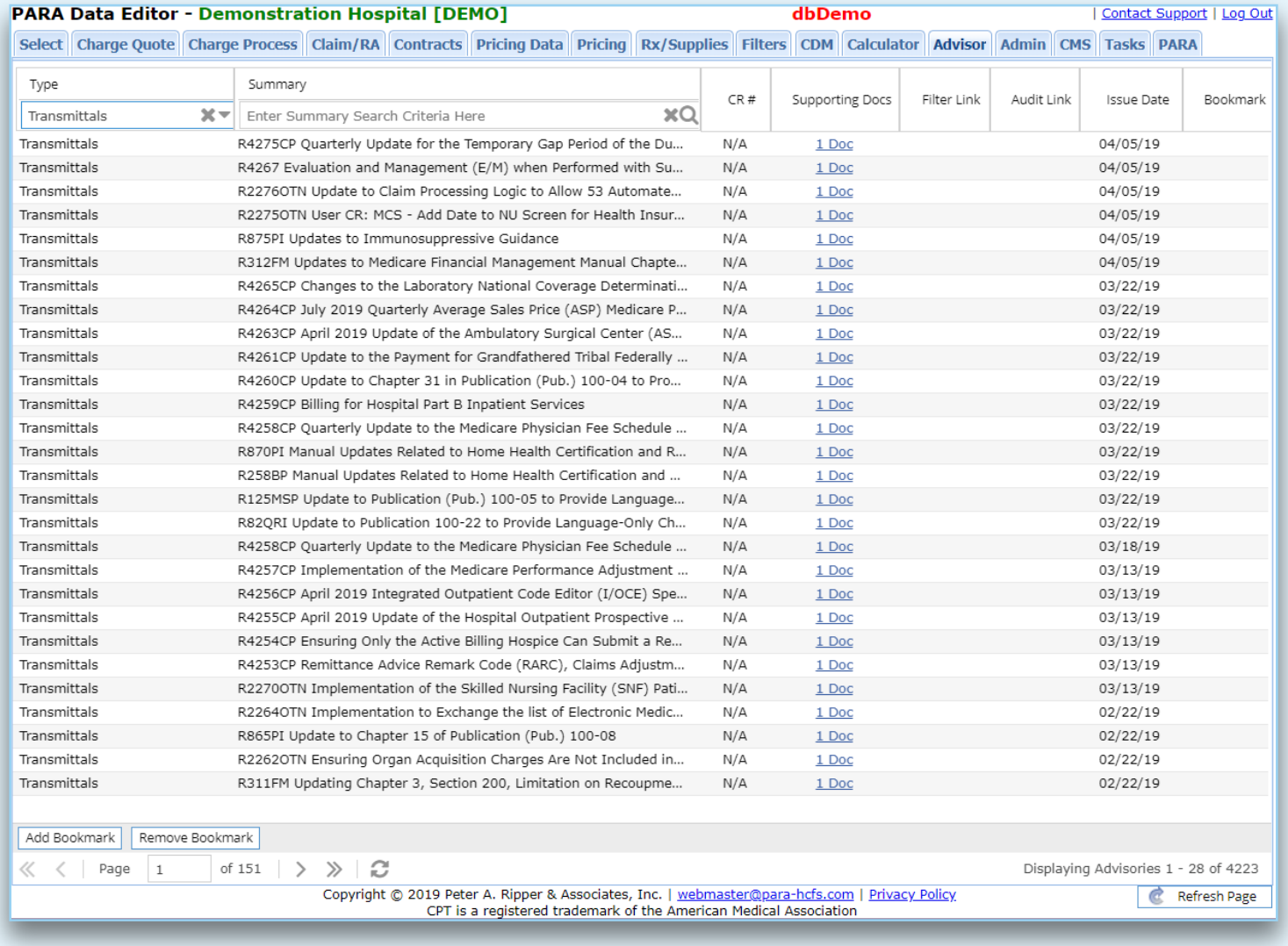

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Transmittals	R4261CP Update to the Payment for Grandfathered Tribal Federally ...	N/A	1 Doc			03/22/19	
Transmittals	R4260CP Update to Chapter 31 in Publication (Pub.) 100-04 to Pro...	N/A	1 Doc			03/22/19	
Transmittals	R4259CP Billing for Hospital Part B Inpatient Services	N/A	1 Doc			03/22/19	
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Page 1 of 151 Displaying Advisories 1 - 28 of 4223

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The link to this Transmittal R10329CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10329	**Date: August 28, 2020**
	Change Request 11932

SUBJECT: Annual Clotting Factor Furnishing Fee Update 2021

I. SUMMARY OF CHANGES: This annually recurring CR announces the update to the Clotting Factor Furnishing Fee.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	17/80/80.4.1 – Clotting Factor Furnishing Fee

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

Recurring Update Notification

The link to this Transmittal R10323CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10323	**Date: August 28, 2020**
	Change Request 11852

SUBJECT: 2021 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

I. SUMMARY OF CHANGES: This change request provides files for the automated payments of HPSA bonuses for dates of service January 1, 2021 through December 31, 2021. This recurring update notification applies to Chapter 4, Section 250.2 and Chapter 12, Section 90.4.2.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

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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
N/A	N/A

III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10331CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10331	**Date: August 28, 2020**
	Change Request 11960

SUBJECT: October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This Recurring Update Notification (RUN) describes changes to and billing instructions for various payment policies implemented in the October 2020 OPPS update. The October 2020 Integrated Outpatient Code Editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this Change Request (CR). This RUN applies to chapter 4, section 50.7.

The October 2020 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming October 2020 I/OCE CR.

EFFECTIVE DATE: 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)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10332CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10332	**Date: August 28, 2020**
	Change Request 11944

SUBJECT: October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3

I. SUMMARY OF CHANGES: This notification provides the Integrated OCE instructions and specifications for the Integrated OCE that will be utilized under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. The attached recurring update notification applies to publication 100-04, chapter 4, section 40.1.

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

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10319CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10319	**Date: August 28, 2020**
	Change Request 11909

SUBJECT: Removal of Contractor Requirement to Submit Electronic Data Interchange (EDI) Data into the Contractor Reporting of Operational and Workload Data (CROWD) System (Form 5)

I. SUMMARY OF CHANGES: Effective with the release of this instruction, contractors are no longer required to submit EDI data into the CROWD system. Contractors shall continue to submit EDI data to CMS Medicare Data Exchange (MDX) per current monthly reporting requirements according to their Statement of Work (SOW) guidelines.

Publication 100-06, Chapter 06, Section 450 has been deleted and publication 100-04, chapter 24, sections 50.1.2 and 80.1 of the Medicare Claims Processing Manual have been amended to reflect this change.

EFFECTIVE DATE: September 29, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 29, 2020

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	24/Table of Contents
R	24/50.1.2/Media
R	24/80.1/Contractor Monthly Status Reporting

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

The link to this Transmittal R10321CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10321	**Date: August 28, 2020**
	Change Request 11858

SUBJECT: Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2021

I. SUMMARY OF CHANGES: A new IRF PRICER software package will be released prior to October 1, 2020, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2020, through September 30, 2021. chapter 3, section 140.2 of publication 100-04 Medicare Claims Processing Manual is being updated accordingly.

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

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II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3 / 140.2 / Payment Provisions Under IRF PPS

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

The link to this Transmittal R10324CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10324	**Date: August 28, 2020**
	Change Request 11881

SUBJECT: 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

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct the contractors and Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform use of CARC, RARC and CAGC rule publications. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2020. This recurring update notification (RUN) applies to chapter 22, section 80.2 of Publication (Pub.) 100-04.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

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

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IV. ATTACHMENTS:

The link to this Transmittal R10330CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10330	Date: August 28, 2020
	Change Request 11959

SUBJECT: Instructions for Retrieving the January 2021 Medicare Physician Fee Schedule Database (MPFSDB) Files Through the CMS Mainframe Telecommunications System

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide instructions for the Medicare contractors to download, test, and implement the annual January MPFSDB update files. In addition, Medicare contractors will need to be prepared to implement up to three revised MPFS payment files for the January update in the event that technical errors are discovered or any other corrections are required.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

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

III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R110322CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10322	**Date: August 28, 2020**
	Change Request 11796

SUBJECT: Claim Status Category and Claim Status Codes Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. This Recurring Update Notification (RUN) can be found in chapter 31, section 20.7 of Publication (Pub.) 100-04.

EFFECTIVE DATE: January 1, 2021
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IMPLEMENTATION DATE: January 4, 2021

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

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10328CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10328	**Date: August 28, 2020**
	Change Request 11907

SUBJECT: January 2021 Healthcare Common Procedure Coding System (HCPCS) Quarterly Update Reminder

I. SUMMARY OF CHANGES: The complete HCPCS file is updated and released quarterly to the Medicare contractors. The file contains existing, new, revised and discontinued HCPCS codes for the January 2021 quarter. Contractors must download the file via the CMS mainframe in December 2020. The recurring update notification applies to chapter 23, section 20 of the Medicare Claims Processing Manual.

EFFECTIVE DATE: January 1, 2021
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IMPLEMENTATION DATE: January 4, 2021

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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
N/A	N/A

III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10334CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10334	**Date: August 28, 2020**
	Change Request 11956

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

I. SUMMARY OF CHANGES: The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The update process for the DMEPOS fee schedule is located in publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.

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

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IV. ATTACHMENTS:

The link to this Transmittal R10320CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10320	**Date: August 28, 2020**
	Change Request 11941

SUBJECT: Updates to Chapter 23 - Fee Schedule Administration and Coding Requirements

I. SUMMARY OF CHANGES: This change request updates Chapter 23 to reflect the quarterly update process for HCPCS files. It also removes outdated instructions from the chapter.

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

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R–REVISED, N–NEW, D–DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	23/Table of Contents
R	23/20/Description of Healthcare Common Procedure Coding System (HCPCS)
R	23/20.1/Use and Maintenance of CPT-4 in HCPCS
R	23/20.2/Local Codes
R	23/20.3/Use and Acceptance of HCPCS Codes and Modifiers
R	23/20.4/Deleted HCPCS Codes/Modifiers
R	23/20.8/Payment, Utilization Review (UR), and Coverage Information on CMS Quarterly HCPCS Codes Update File
R	23/50.6/Physician Fee Schedule Payment Policy Indicator File Record Layout

III. FUNDING:
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The link to this Transmittal R10325CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10325	**Date: August 28, 2020**
	Change Request 11891

SUBJECT: Combined Common Edits/Enhancements Modules (CCEM) Code Set Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to direct the Medicare shared system maintainers to obtain the most recent external code sets, and use them to update the necessary tables and/or reference files as part of the CCEM software utilized by the A/B Medicare Administrative Contractors (MACs). This recurring update notification applies to publication 100-04, chapter 24, section 50.3.4.

EFFECTIVE DATE: January 1, 2021
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IMPLEMENTATION DATE: January 4, 2021

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10336DEMO

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10336	**Date: August 27, 2020**
	Change Request 11897

Transmittal 10260, dated July 31, 2020, is being rescinded and replaced by Transmittal 10336, dated, August 27, 2020, to correct the dates in the background section. All other information remains the same.

SUBJECT: Implementation of Nurse Practitioners Certifying Diabetic Shoe Orders Under the Primary Care First (PCF) Model

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) under the Primary Care First (PCF) model is to provide a benefit enhancement to nurse practitioner participants. Specifically, this enhancement is for nurse practitioners in PCF to certify diabetic shoe orders for their attributed beneficiaries.

EFFECTIVE DATE: January 1, 2021
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IMPLEMENTATION DATE: January 4, 2021

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

III. FUNDING:

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IV. ATTACHMENTS:
Demonstrations

The link to this Transmittal R10337CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10337	**Date: August 27, 2020**
	Change Request 11755

Transmittal 1028, dated May 8, 2020, is being rescinded and replaced by Transmittal 10337, dated, August 27, 2020, to change business requirement 11755-04.2.1.1 to deny claims and provides revised messaging. The Claims Processing Manual at section 410.4 has been revised accordingly. All other information remains the same.

SUBJECT: National Coverage Determination (NCD30.3.3): Acupuncture for Chronic Low Back Pain (cLBP)

I. SUMMARY OF CHANGES: The purpose of this change request is to inform MACs that CMS will cover acupuncture for chronic low back pain (cLBP) effective for claims with dates of service on and after January 21, 2020.

EFFECTIVE DATE: January 21, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020 - A/B MACs and SSM Edits (except BR 13); January 4, 2021 - BR 13 CWF only

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	32/410/Table of Contents
R	32/410/Acupuncture for Chronic Low Back Pain (cLBP)
N	32/410/2/Claims Processing General Information
N	32/410/3/Institutional Claims Bill Type and Revenue Coding Information
N	32/410/4/Messaging
N	32/410/5/Common Working File (CWF) Editing

III. FUNDING:

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The link to this Transmittal R10337NCD

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-03 Medicare National Coverage Determinations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10337	**Date: August 27, 2020**
	Change Request 11755

Transmittal 10128, dated May 8, 2020, is being rescinded and replaced by Transmittal 10337, dated, August 27, 2020, to change business requirement 11755-04.2.1.1 to deny claims and provides revised messaging. The Claims Processing Manual at section 410.4 has been revised accordingly. All other information remains the same.

SUBJECT: National Coverage Determination (NCD30.3.3): Acupuncture for Chronic Low Back Pain (cLBP)

I. SUMMARY OF CHANGES: The purpose of this change request is to inform MACs that CMS will cover acupuncture for chronic low back pain (cLBP) effective for claims with dates of service on and after January 21, 2020.

The Federal government creates NCDs that are binding on the MACs who review and/or adjudicate claims, make coverage determinations, and/or payment decisions, and also binds quality improvement organizations, qualified independent contractors, the Medicare appeals council, and Administrative Law Judges (ALJs) (see 42 Code of Federal Regulations (CFR) section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

EFFECTIVE DATE: January 21, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020 - A/B MACs and SSM Edits (except BR 13); January 4, 2021 - BR 13 CWF only

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/30.3/Table of Contents/Acupuncture
N	1/30/3.3/ACUPUNCTURE for Chronic Lower Back Pain (cLBP)
R	1/30./3.1/Acupuncture for Fibromyalgia
R	1/30/3.2/ ACUPUNCTURE FOR OSTEOARTHRITIS

III. FUNDING:

The link to this Transmittal R10338CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10338	**Date: August 27, 2020**
	Change Request 11876

NOTE: This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet. Transmittal 10232, dated August 6, 2020, is being rescinded and replaced by Transmittal 10338, dated, August 27, 2020 to update the policy section, revise Business Requirement (BR) 11876.3 and to add BRs 11876.3.1, 11876.3.2 and 11876.4 and to revise the Hospice Rate Tables attachment. All other information remains the same.

SUBJECT: Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2021

I. SUMMARY OF CHANGES: This Change Request (CR) updates the hospice payment rates, hospice wage index, and Pricer for FY 2021. The CR also updates the FY 2021 hospice aggregate cap amount. These updates apply to Pub 100-04, Chapter 11, section 30.2.

EFFECTIVE DATE: 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)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

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

IV. ATTACHMENTS:

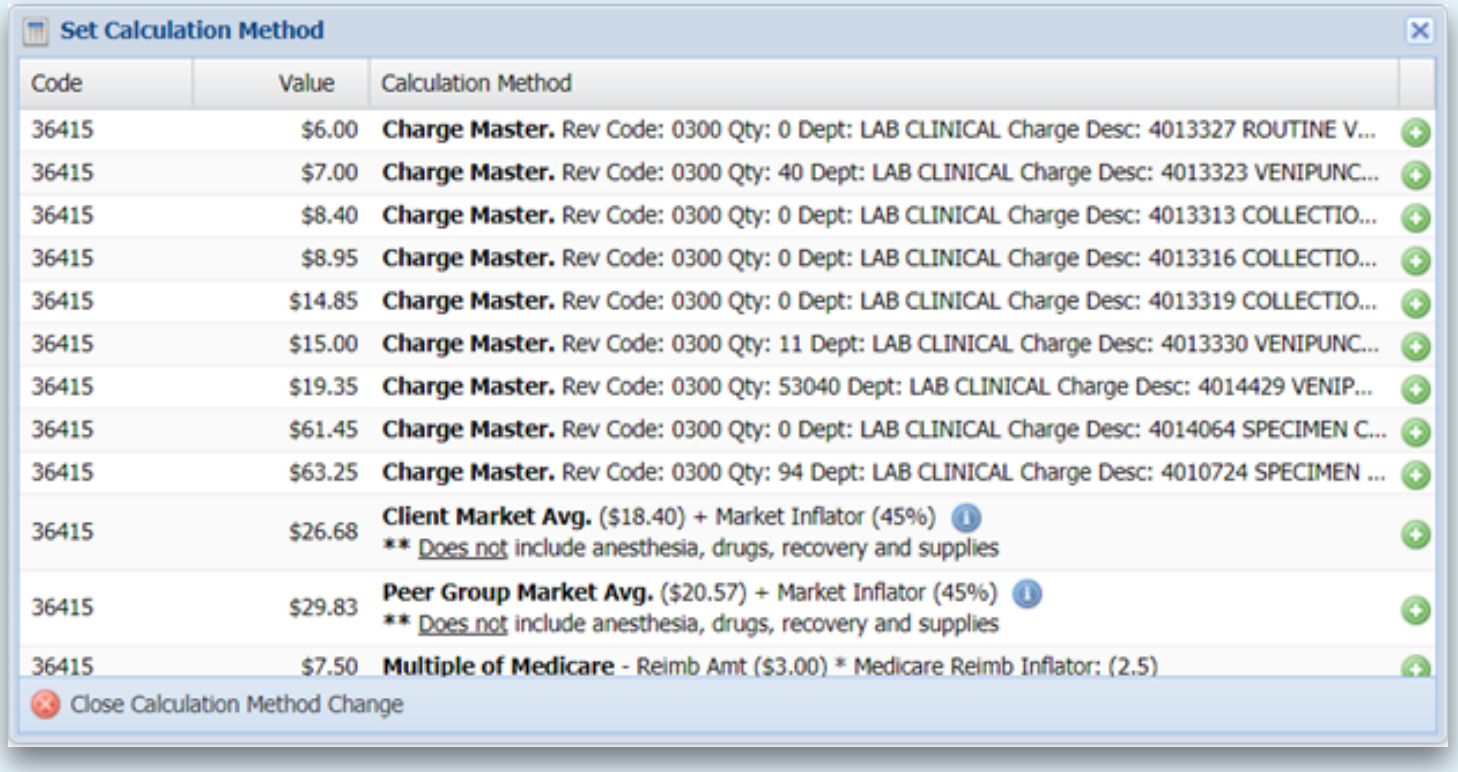
Recurring Update Notification

Special Notice

PDE Charge Quote/Share Of Cost Updates

In an ongoing effort to increase pricing transparency, **PARA** has made some upgrades to the **Charge Quote/Share of Cost** module within the **PDE**.In addition to increasing functionality in Medicare Critical Access Hospital settlement, quote creators now have more flexibility in choosing what prices appear within the quote itself.

With the increased transparency in price selection, some functionality has changed.Prices will no longer automatically load into the quote, unless the item is a single line item in the chargemaster. If there are multiple line items in the chargemaster with the same CPT® code, users will be presented with all line items for selection, instead of an average price being calculated.Users will be required to select a line item for the price to be added to the quote:



All Prices, revenue codes, department codes and usage quantity appear, allowing the creator to select the most appropriate item for addition to the quote.Client and Peer market averages are also still available, as is the multiple of Medicare option.Selection of packages and the Search function have not been affected.

If you have any questions or need assistance with any of the new functionality, please contact Mary McDonnell at (800) 999-3332 ext. 216 or mmcdonnell@para-hcfs.com.

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WHAT WE OFFER

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- Contingency-Based Flat Rate Fee Schedule
- 25% Reduction In Account Lifecycle

- 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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