DME Happenings

Jurisdiction D

December 2019

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CLINICIAN'S CORNER

This Bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no-cost from our website at: http://med.noridianmedicare.com

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2019-2020 Influenza (Flu) Resources for Health Care Professionals

MLN Matters Number: SE19022
Article Release Date: September 9, 2019

Special Edition (SE) MLN Matters article SE19022 provides information about influenza (flu) resources for health care professionals and providers relevant to the 2019-2020 flu season. Health care professionals should:

- Keep this article and refer to it throughout the 2019-2020 flu season.
- Take advantage of each office visit as an opportunity to encourage patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot if you have vaccine available, even after the new year.
- Remember to immunize yourself and your staff.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)19022.

Implementation to Exchange the List of eMDRs for Registered Providers via the esMD System - Revised

MLN Matters Number: MM11003 Revised
Related CR Release Date: April 16, 2019
Related CR Transmittal Number: R2281OTN
Related Change Request (CR) Number: 11003
Effective Date: July 1, 2019
Implementation Date: July 1, 2019

Note: CMS revised this article on November 1, 2019, to update and clarify information regarding the eMDR registration/enrollment to indicate the provider and the HIH roles with more detail. All other information is unchanged.

CR 11003 introduced the enrollment process for the providers who intend to get their Additional Documentation Request (ADR) letters electronically (as eMDR) through their registered Health Information Handler (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Which_HIHs_Plan_to_Offer_Gateway_Services_to_Providers). Make sure your billing staffs are aware of these changes.

In response to a number of requests from Medicare providers, the Centers for Medicare & Medicaid Services (CMS) is adding the functionality to send ADR letters electronically. CMS conducted a pilot supporting the electronic version of the ADR letter known as Electronic Medical Documentation Request (eMDR) via the Electronic Submission of Medical Documentation (esMD) system.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11003.

Ostomies are Life-Savers

October 5 is Ostomy Awareness Day, increasing awareness of bowel and urinary diversion surgery and proper care for patients. Review the Provider Compliance Tips for Ostomy Supplies Medicare Learning Network Fact Sheet and learn about:

- Coverage requirements
- Billing
- Guidelines for refills

Source: CMS MLN Connects for October 3, 2019

Ankle Foot/Knee-Ankle-Foot Orthosis (AFO/KAFO) Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) L4360, L4361, L4386 and L4387. The quarterly edit effectiveness results from April 2019 - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **51%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Claim is the same or similar to another claim on file.
- Documentation does not include verification that the equipment was lost, stolen or irreparably damaged in a specific incident.
- Documentation does not support coverage criteria

For complete detail see, Ankle Foot/Knee-Ankle-Foot Orthosis (AFO/KAFO) Quarterly Results of Targeted Probe and Educate Review.

CERT Claim Reviews - Respond Timely

Have you received a Comprehensive Error Rate Testing (CERT) audit letter? Timely response is critical to the success of reducing the overall national improper payment rate.

Perhaps you have responded yet still received a denial? Appeal rights are afforded to you for CERT decisions resulting in either an overpayment or an underpayment and should be appealed if a supplier/provider disagrees with the decision, regardless of the dollar amount associated.

Visit the CERT Review Process webpage to access details and the Redetermination webpage for first level of appeal options.

Enteral Nutrition Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) B4150, B4152, and B4154. The quarterly edit effectiveness results from April 2019 - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **34%**.

Top Denial Reasons

- Documentation does not support coverage criteria
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- No medical record documentation was received. Refer to Medicare Program Integrity Manual 3.2.3.8.

For complete detail see, Enteral Nutrition Quarterly Results of Targeted Probe and Educate Review.

Glucose Monitors Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) A4253. The quarterly edit effectiveness results from April 2019 - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **53%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- No medical record documentation was received.
- Documentation does not support high utilization

For complete detail see, Glucose Monitors Quarterly Results of Targeted Probe and Educate Review.

Immunosuppressive Drugs Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) J7507, J7517, J7518, and J7520. The quarterly edit effectiveness results from April 2019 - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **7%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not include a Detailed Written Order (DWO).

For complete detail see, Immunosuppressive Drugs Quarterly Results of Targeted Probe and Educate Review.

Knee Orthosis Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) L1810, L1812, L1830, L1832, L1833, L1843, L1845, and L1852. The quarterly edit effectiveness results from April - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **54%**.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Claim is the same or similar to another claim on file.

For complete detail see, Knee Orthosis Quarterly Results of Targeted Probe and Educate Review.

Manual Wheelchair Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) K0001 and K0003. The quarterly edit effectiveness results from April 2019 - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **26%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria

For complete detail see, Manual Wheelchair Quarterly Results of Targeted Probe and Educate Review.

Oral Anticancer Drugs Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) WW005, WW006, WW090, and WW093. The quarterly edit effectiveness results from April 2019 - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **39%**.

Top Denial Reasons

- No medical record documentation was received. Refer to Medicare Program Integrity Manual 3.2.3.8.
- Refill request documentation is incomplete or missing elements.

- Detailed Written Order (DWO) is incomplete or missing elements.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For complete detail see, Oral Anticancer Drugs Quarterly Results of Targeted Probe and Educate Review.

Ostomy Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) A4407 and A4409. The quarterly edit effectiveness results from April - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **39%**.

Top Denial Reasons

- Refill request documentation is incomplete or missing elements.
- No medical record documentation was received. Refer to Medicare Program Integrity Manual 3.2.3.8.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter

For complete detail see, Ostomy Quarterly Results of Targeted Probe and Educate Review.

Oxygen and Oxygen Equipment Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) E0424, E0431, E0434, E0439, and E1390. The quarterly edit effectiveness results from April 2019 - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **32%**.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For complete detail see, Oxygen Quarterly Results of Targeted Probe and Educate Review.

Parenteral Nutrition Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) B4185, B4193, B4197 and B4199. The quarterly edit effectiveness results from April - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **17%**.

Top Denial Reason

- Documentation does not support coverage criteria.

For complete detail see, Parenteral Nutrition Quarterly Results of Targeted Probe and Educate Review.

Positive Airway Pressure (PAP) Devices Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) E0601. The quarterly edit effectiveness results from April - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **13%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Written Order Prior to Delivery (WOPD) is incomplete or missing elements.
- Detailed Written Order (DWO) is incomplete or missing elements

For complete detail see, PAP Quarterly Results of Targeted Probe and Educate Review.

Spinal Orthoses Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) L0625, L0626, L0627, L0630, L0631, L0637, L0641, L0642, L0643, L0648, and L0650. The quarterly edit effectiveness results from April 2019 - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **60%**.

Top Denial Reasons

- Claim is the same or similar to another claim on file.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not include verification that the equipment was lost, stolen or irreparably damaged in a specific incident.
- No medical record documentation was received.

For complete detail see, Spinal Orthoses Quarterly Results of Targeted Probe and Educate Review.

Surgical Dressings Targeted Probe and Educate Review Updates: January - March 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) A6021, A6212, A6196, and A6197. The quarterly edit effectiveness results from April 2019 - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **82%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Medical record documentation was not received.

For complete detail see, Surgical Dressings Quarterly Results of Targeted Probe and Educate Review.

Therapeutic Shoes Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) A5500. The quarterly edit effectiveness results from April - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **49%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.

For complete detail see, Therapeutic Shoes Quarterly Results of Targeted Probe and Educate Review.

Urological Supplies Targeted Probe and Educate Review Updates: April - June 2019

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) A4351, A4353, and A4358. The quarterly edit effectiveness results from April 2019 - June 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **37%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Claim is billed for greater quantity than the Detailed Written Order (DWO) indicates.
- Detailed Written Order (DWO) is incomplete or missing elements.

For complete detail see, Urological Supplies Quarterly Results of Targeted Probe and Educate Review.

Claim Denial Rate Calculator Now Available

Noridian now has a Claim Denial Rate Calculator which allows suppliers to determine denial percentages for all their claims, including individual denial rate for Target Probe and Educate (TPE) review, denial rates for individual policy categories, or determine overall Medicare dollar percentages denied.

Find this tool on the Claims and Appeals webpage.

Diabetic Testing Supplies: Glucose Monitor Claim Requirement Effective On/After DOS March 1, 2020

Noridian has identified a significant number of claims for diabetic test strips (HCPCS A4253) and lancets (HCPCS A4259) that did not have a glucose monitor on file nor included any indication, within the claim, that the beneficiary owned a monitor.

With diabetic testing supply HCPCS codes A4253 and A4259 being covered as a supply to the glucose monitor HCPCS codes E0607, E2100, or E2101, claims for dates of service (DOS) on/after March 1, 2020 must require one of the below.

- A claim on file for HCPCS E0607, E2100, or E2101

OR

- A narrative within Item 19 of CMS-1500 Claim Form or its electronic equivalent indicating beneficiary owned HCPCS E0607, E2100, or E2101 and its approximate purchase date
- Example: Beneficiary owned E0607. Purchased 09/15/2011

If there is no glucose monitor in the Medicare claims history or the narrative is missing, the claim will deny as missing the equipment that requires the supply.

Organization of Clinician's Corner

Noridian created the Clinician's Corner to assist clinician's with gaining a better understanding of the coverage and documentation requirements when ordering durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to Medicare beneficiaries. Within this resource is a Clinician Checklist section which was recently reorganized into various categories to locate the over 50 checklists easier.

HCPCS E1028: Accessory HCPCS Required for Dates of Service on/after March 1, 2020

When billing HCPCS E1028 for dates of service on/after January 1, 2020, Item 19 of the CMS-1500 claim form or the electronic equivalent must include the accessory HCPCS code for which HCPCS E1028 was used. If left blank, the claim will reject as unprocessable.

Because an unprocessable claim does not have appeal rights, it cannot be reopened or submitted for adjustment. It must be resubmitted as a new claim.

Articulating Digit(s) and Prosthetic Hands - Correct Coding Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Articulating Digit(s) and Prosthetic Hands - Correct Coding Revised, has been created and published to our website.

View the locally hosted 2019 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Continuous Glucose Monitor Supplies - Correct Coding and Billing - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Continuous Glucose Monitor Supplies - Correct Coding and Billing, has been created and published to our website.

View the locally hosted 2019 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Contractor Advisory Committee (CAC) Meeting Information - Oxygen and Oxygen Equipment (L33797)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Contractor Advisory Committee (CAC) Meeting Information - Oxygen and Oxygen Equipment (L33797), has been created and published to our website.

View the locally hosted 2019 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

LIM Innovation Infinite Socket - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, LIM Innovation Infinite Socket - Correct Coding - Revised, has been created and published to our website.

View the locally hosted 2019 DMD articles.

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  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Panzyga® (Immunoglobulin Intravenous (Human), 10%) Correct Coding and Coverage - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Panzyga® (Immunoglobulin Intravenous (Human), 10%) Correct Coding and Coverage - Revised, has been created and published to our website.

View the locally hosted 2019 DMD articles.

- Go to Noridian Medical Director Articles webpage
    - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Policy Article Revisions Summary for September 5, 2019

Outlined below are the principal changes to the DME MAC Policy Article (PA) that has been revised and posted. The policy included is Therapeutic Shoes for Persons with Diabetes. Please review the entire LCD and related PA for complete information.

Therapeutic Shoes for Persons with Diabetes
PA
Revision Effective Date: 01/01/2019

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: HCPCS A5514 to the reference of “inserts” for which impressions, casts, or CAD-CAM images, of the beneficiary’s feet, are to be obtained by the supplier at the time of item selection

09/05/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Note: The information contained in this article is only a summary of revisions to the LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

Topical Oxygen Therapy Contractor Advisory Committee (CAC) Agenda

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Topical Oxygen Therapy Contractor Advisory Committee (CAC) Agenda, has been created and published to our website.

View the locally hosted 2019 DMD articles.

- Go to Noridian Medical Director Articles webpage
    - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Hurricane Dorian and Medicare Disaster Related Commonwealth of Puerto Rico Claims

MLN Matters Number: SE19017
Article Release Date: August 30, 2019

The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the Commonwealth of Puerto Rico on August 28, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 26, 2019, and are in effect for 90 days.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)19017.

Hurricane Dorian and Medicare Disaster Related State of Florida Claims

MLN Matters Number: SE19018
Article Release Date: September 3, 2019

The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the State of Florida on August 30, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 28, 2019, and are in effect for 90 days.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)19018.

Hurricane Dorian and Medicare Disaster Related States of Georgia and South Carolina Claims

MLN Matters Number: SE19019
Article Release Date: September 4, 2019

The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the States of Georgia and South Carolina on September 2, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 29, 2019, for Georgia, and retroactive to August 31, 2019, for South Carolina. The PHE is in effect for 90 days.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)19019.

Hurricane Dorian and Medicare Disaster Related State of North Carolina Claims

MLN Matters Number: SE19020
Article Release Date: September 5, 2019

The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the State of North Carolina on September 4, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 1, 2019, and are in effect for 90 days.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)19020.

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - October 2019 - Revised

MLN Matters Number: MM11343 Revised
Related CR Release Date: September 13, 2019
Related CR Transmittal Number: R4395CP
Related Change Request (CR) Number: 11343
Effective Date: October 1, 2019
Implementation Date: October 7, 2019

Note: CMS revised this article on September 16, 2019, to reflect the revised CR11343 issued on September 13. The CR revision had no impact on the substance of the article. CMS did update the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

CR11343 informs MACs about new and revised Average Sales Price (ASP) and ASP Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. The Centers for Medicare & Medicaid Services (CMS) will make files available for download on or after September 13, 2019. CMS gives MACs the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions available in Chapter 4, Section 50 of the Medicare Claims Processing Manual found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf. Make sure that your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11343.

DMEPOS Fee Schedule - October 2019 Quarterly Update

MLN Matters Number: MM11433
Related CR Release Date: August 30, 2019
Related CR Transmittal Number: R4386CP
Related Change Request (CR) Number: 11433
Effective Date: September 1, 2019 for implementation of fees for code E0766; October 1, 2019 for all other changes
Implementation: October 7, 2019

CR 11433 informs DME MACs about the changes to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule that Medicare updates on a quarterly basis when necessary to implement fee schedule amounts for new codes. In addition, the update corrects any fee schedule amounts for existing codes and updates to the DMEPOS Rural ZIP code file. Make sure your billing staff are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11433.

ICD-10 and Other Coding Revisions to NCDs - January 2020 Update - Revised

MLN Matters Number: MM11392 Revised
Related CR Release Date: September 19, 2019
Related CR Transmittal Number: R2362OTN
Related Change Request (CR) Number: 11392
Effective Date: January 1, 2020
Implementation Date: January 6, 2020 -MAC local edits 45 days from date of this CR

Note: We revised this article on September 23, 2019, due the release of an updated Change Request (CR).The update added to the CR: (1) a revised spreadsheet for NCD110.23, requirement 3, (2) FISS responsibility and new verbiage to NCD150.3, requirement 4 and associated spreadsheet, and, (3) revised verbiage to NCD110.21, requirement 11. All other information remains the same.

CR 11392 constitutes a maintenance update of International Classification of Diseases (ICD)-10 conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11392.

MBI Displays in Remittance Advice - Update Your Files Before December 31, 2019

The Medicare Beneficiary Identifier (MBI) transition from the Health Insurance Claim Number (HICN) will end December 31, 2019. When a claim is submitted with a HICN, the remittance advice will return and display the MBI. However, the feature of displaying MBIs on remittance advices when an HICN is submitted on the claim will no longer be available effective January 1, 2020. Any duplicate remittance advices ordered will also no longer display the MBI after January 1, 2020. For the remaining six weeks until the mandatory MBI submission date, Noridian encourages providers/suppliers to use their Medicare remittance advices to obtain the MBIs and update their records.

Starting January 1, 2020, you MUST submit claims using MBIs (with a few exceptions), no matter what date you performed the service. Claims will be rejected if they are submitted with HICNs on/after January 1, 2020.

Resources:

- CMS Medicare Learning Network (MLN) Matters Special Edition (SE)18006
- CMS Medicare Beneficiary Identifiers (MBIs) Provider Webpage

Medicare Beneficiary Identifiers (MBIs) For Ordering and Referring Providers

January 1, 2020 is right around the corner, which marks the day that only the MBI (regardless of date of service) will be accepted. This is a reminder that there are many providers you do business with who never see the patient such as a laboratory, reading radiologist or durable medical supplier (DME). These providers will need you to make sure you are providing them with the MBI number on your referrals and orders.

In addition, after January 1, remittance advices will no longer contain the crossover information this may increase calls to your offices requesting MBI information.

New Medicare Card: Claim Reject Codes After January 1

Starting January 1, 2020, you must use Medicare Beneficiary Identifiers (MBIs) when billing Medicare regardless of the date of service. We will reject claims submitted with Health Insurance Claim Numbers (HICNs) with a few exceptions. We will reject all eligibility transactions submitted with HICNs.

If you do not use MBIs on claims after January 1, you will get:

- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

Do not wait. Protect your patients' identities by using MBIs now for all Medicare transactions. Need an MBI?

- Ask your patients for their cards. If they did not get a new card, give them the Get Your New Medicare Card flyer in English or Spanish.
- Use your Medicare Administrative Contractor's look-up tool. Sign up for the Portal to use the tool.
- Check the remittance advice. We return the MBI on the remittance advice for every claim with a valid and active HICN.

Resources

- CMS MLN Matters Article SE18006 Reissued: New Medicare Beneficiary Identifier (MBI) Get It, Use It
- CMS MLN Connects dated October 24, 2019
- CMS MBI provider webpage

New Medicare Card: HICN Claims Reject January 1, 2020

Starting January 1, you must use Medicare Beneficiary Identifiers (MBIs) when billing Medicare regardless of the date of service. We will reject claims submitted with Health Insurance Claim Numbers (HICNs) with a few exceptions. We will reject all eligibility transactions submitted with HICNs.

See the CMS Medicare Learning Network (MLN) Matters (MM) Special Edition (SE)18006 to learn how to get and use MBIs.

Source

- CMS *MLN Connects* dated November 7, 2019

MLN Connects - September 5, 2019

MLN Connects - September is Pain Awareness Month - Learn Pain Management Options

MLN Connects® for Thursday, September 5, 2019
View this edition as a PDF

News

- New Medicare Card: Do You Refer Patients?
- IRF Appeals Settlement Option: Deadline September 17
- Quality Payment Program: MIPS Targeted Review Request Deadline September 30
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- PEPPERs for Short-term Acute Care Hospitals
- DME QIC Contract Award
- Health Care Supply Chain, Provider Self-Care, and Emergency Preparedness Resources
- September is Pain Awareness Month

Compliance

- Chiropractic Services: Comply with Medicare Billing Requirements

Events

- Dementia Care: Supporting Comfort and Resident Preferences Call - September 10
- Health Coaching and Wellness Planning for Self-Management Webinar - September 10
- New Medicare Card: Open Door Forum - September 11
- Developing a Hospice Patient Assessment Tool Special Open Door Forum - September 12
- Opioids: What's an "Outlier Prescriber"? Listening Session - September 17
- CMS Public Meeting: Action Plan to Prevent and Manage Opioid Use Disorder and Substance Use Disorder and Address Pain Management - September 20

MLN Matters® Articles

- Hurricane Dorian and Medicare Disaster Related State of Florida Claims
- Hurricane Dorian and Medicare Disaster Related States of Georgia and South Carolina Claims
- Hurricane Dorian and Medicare Disaster Related Commonwealth of Puerto Rico Claims
- 2020 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update
- Annual Clotting Factor Furnishing Fee Update 2020
- Influenza Vaccine Payment Allowances - Annual Update for 2019-2020 Season
- October 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.3
- October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- October Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Multimedia

- CMS: Beyond the Policy Podcast: Dispatches from the Blue Button Developers Conference

MLN Connects - September 12, 2019

MLN Connects - New Medicare Card Transition Period Ends in Less Than 4 Months

MLN Connects® for Thursday, September 12, 2019
View this edition as a PDF

News

- New Medicare Card: Transition Period Ends in Less Than 4 Months
- New Enforcement Authorities to Reduce Criminal Behavior in Medicare, Medicaid, and CHIP

- Different-Day Upper and Lower Endoscopy: Comparative Billing Report in September
- Hospices: Call for Panel on Assessment Instrument and Quality Measures - Nominations due September 30
- Local Coverage Determination Meetings
- Pain Management: CDC Conversation Starters for Patients and Their Doctors
- Healthy Aging® Month: Discuss Preventive Services with your Patients

Compliance

- Bill Correctly for Device Replacement Procedures

Claims, Pricers Codes

- Average Sales Price Files: October 2019

Events

- Opioids: What's an "Outlier Prescriber"? Listening Session - September 17
- Different-Day Upper and Lower Endoscopy: Comparative Billing Report Webinar - September 24

MLN Matters® Articles

- Hurricane Dorian and Medicare Disaster Related State of North Carolina Claims
- Additional Instructions to Hospitals on the Election of a Medicare-Supplemental Security Income (SSI) Component of the Disproportionate Share (DSH) Payment Adjustment for Cost Reports that Involve SSI Ratios for Fiscal Year (FY) 2004 and Earlier, or SSI Ratios for Hospital Cost-Reporting Periods for Patient Discharges Occurring Before October 1, 2004
- October 2019 Update of the Ambulatory Surgical Center (ACS) Payment System
- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update - Revised
- Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting and Reporting Data for the Private Payor Rate-Based Payment System - Revised
- 2020 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments - Revised

Publications

- Medicare Part A Cost Report Electronic Filing
- Quality Payment Program: 2019 MIPS Resources
- Advance Care Planning - Revised
- Medicare Billing: CMS Form CMS-1500 and the 837 Professional - Revised
- Medicare Secondary Payer- Revised
- Roadmap to Behavioral Health - Updated

Multimedia

- Home Health Call: Audio Recording and Transcript
- Radiation Oncology Listening Session: Audio Recording and Transcript
- SNF Value-Based Purchasing Call: Audio Recording and Transcript
- Medicare Secondary Payer Provisions Web-Based Training Course - Revised
- Quality Payment Program for Merit-based Incentive Payment System (MIPS) APMs in 2019 Web-Based Training Course - Revised
- SNF PPS: Patient Driven Payment Model Videos

MLN Connects - September 19, 2019

MLN Connects - Why Use the MBI?

MLN Connects® for Thursday, September 19, 2019
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News

- New Medicare Card: Why Use the MBI?
- Proposed Opioid Treatment Program Policies: Comment Deadline September 27

- Quality Payment Program: MIPS Targeted Review Request Deadline September 30
- SNF PPS Patient Driven Payment Model Resources: Get Ready for October 1
- Emergency Triage, Treat, and Transport Model: Apply by October 5
- LTCH Provider Preview Reports: Review Your Data by October 11
- IRF Provider Preview Reports: Review Your Data by October 11
- Hospice Provider Preview Reports: Review Your Data by October 11
- Prostate Cancer Awareness Month

Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

MLN Matters® Articles

- 2019-2020 Influenza (Flu) Resources for Health Care Professionals
- Billing for Hospital Part B Inpatient Services

Publications

- Medicare Enrollment for Institutional Providers - Reminder
- Medicare Enrollment Resources Educational Tool - Reminder
- PECOS FAQs Booklet - Reminder
- PECOS Technical Assistance Contact Information Fact Sheet - Reminder

MLN Connects - September 26, 2019

MLN Connects - More Questions About Using the MBI?

MLN Connects® for Thursday, September 26, 2019
View this edition as a PDF

News

- New Medicare Card: More Questions about Using the MBI?
- Quality Payment Program: Submit Comments on 2020 Proposed Rule by September 27
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- 2019 QRDA I Implementation Guide and Sample File for Hospital Quality Reporting: Updated
- Post-Acute Care and Hospice Utilization and Payment Public Use Files
- Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Hospice Quality Reporting Program Quarterly Updates
- National Cholesterol Education Month and World Heart Day

Compliance

- DME Proof of Delivery Documentation Requirements

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- IRF/LTCH: Reporting Health Care Personnel Influenza Vaccination Data Webinars - October 1, 3, or 9

MLN Matters® Articles

- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2020
- October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - Revised
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update - Revised

Publications

- Quality Payment Program: Resources for Clinicians New to the Program in 2019
- Medicare Enrollment for Physicians and Other Part B Suppliers - Reminder
- Medicare Preventive Services Poster - Reminder
- Safeguard Your Identity and Privacy Using PECOS - Reminder

Multimedia

- Quality Payment Program: All-Payer Combination Option in 2019 Web-Based Training Course
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Promoting Interoperability Performance Category in 2019 Web-Based Training Course
- Dementia Care Call: Audio Recording and Transcript
- Quality Payment Program for Advanced APMs in 2019 Web-Based Training Course - Revised
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Participation in 2019 Web-Based Training Course - Revised
- Transitioning to an Advanced APM: 2019 Update Web-Based Training Course - Revised

MLN Connects Special Edition - September 26, 2019

Omnibus Burden Reduction (Conditions of Participation) Final Rule

On September 26, CMS took action at President Trump's direction to "cut the red tape," by reducing unnecessary burden for American's health care providers allowing them to focus on their priority - patients. The Omnibus Burden Reduction (Conditions of Participation) Final Rule removes Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other health care providers to reduce inefficiencies and moves the nation closer to a health care system that delivers value, high quality care and better outcomes for patients at the lowest possible cost.

This rule advances the Patients over Paperwork initiative by saving providers an estimated 4.4 million hours of time previously spent on paperwork with an overall total projected savings to providers of $800 million annually.

This rule finalizes the provisions of three proposed rules

- Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction ("Omnibus Burden reduction"), published September 20, 2018
- Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, published June 16, 2016
- Fire Safety Requirements for Certain Dialysis Facilities, published November 4, 2016.

For More Information:

- Final Rule
- Press Release

Press release See the full text of this excerpted CMS Fact Sheet (Issued September 26).

Discharge Planning Rule Supports Interoperability and Patient Preferences

On September 26, CMS issued a final rule that empowers patients preparing to move from acute care into Post-Acute Care (PAC), a process called discharge planning. The rule puts patients in the driver's seat of their care transitions and improves quality by requiring hospitals to provide patients access to information about PAC provider choices, including performance on important quality measures and resource-use measures, including:

- Number of pressure ulcers
- Proportion of falls that lead to injury
- Number of readmissions back to the hospital

The rule also:

- Advances CMS's interoperability efforts by requiring the seamless exchange of patient information between health care settings, and ensuring that a patient's health care information follows them after discharge from a hospital or PAC provider.

- Revises the discharge planning requirements that hospitals (including long-term care hospitals, Critical Access Hospitals (CAHs) psychiatric hospitals, children's hospitals, and cancer hospitals), inpatient rehabilitation facilities, and home health agencies must meet to participate in Medicare and Medicaid programs. It requires the discharge planning process to focus on a patient's goals and treatment preferences. Hospitals are mandated to ensure each patient's right to access their medical records in an electronic format.
- Implements requirements from the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) that includes how facilities will account for and document a patient's goals of care and treatment preferences.

Hospitals and CAHs are already conducting most of the revised discharge planning requirements, with the exception of the discharge planning requirements of the IMPACT Act.

For More Information:

- Fact Sheet
- Final Rule

See the full text of this excerpted CMS Press Release (Issued September 26).

MLN Connects Special Edition - September 30, 2019

New HCPCS Code J0642 for Levoleucovorin Injection

For dates of service on or after October 1, use HCPCS code J0642 for levoleucovorin injection products marketed under the brand name of Khapzory.

MLN Connects - October 3, 2019

MLN Connects - New Medicare Card: Do You Refer Patients?

MLN Connects® for Thursday, October 3, 2019
View this edition as a PDF

News

- New Medicare Card: Do You Refer Patients?
- Opioid Treatment Programs: Get Ready to Participate in the New Benefit
- Home Health Preview Reports for January 2020 Refresh
- LTCH Provider Preview Reports: Review Your Data by October 11
- IRF Provider Preview Reports: Review Your Data by October 11
- Hospice Provider Preview Reports: Review Your Data by October 11
- CLFS CY 2020 Preliminary Payment Determinations: Comment by October 27
- MIPS: Virtual Group Election Period Open Through December 31
- LTCH Compare Refresh
- IRF Compare Refresh
- Qualified Medicare Beneficiary Billing Requirements
- Ostomies are Life-Savers
- Looking for Educational Materials?

Compliance

- Outpatient Services Payment: Beneficiaries Who Are Inpatients of Other Facilities

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020
- January 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - January 2020 Update - Revised

Publications

- Quality Payment Program: 2019 APM Incentive Payment Fact Sheet
- Billing Information for Rural Providers and Suppliers - Revised

Multimedia

- Reducing Opioid Misuse Listening Session: Audio Recording and Transcript
- SNF PPS: Patient Driven Payment Model Videos

MLN Connects Special Edition - October 9, 2019

Modernizing and Clarifying the Physician Self-Referral Regulations Proposed Rule

On October 9, CMS issued a proposed rule to modernize and clarify the regulations that interpret the Medicare physician self-referral law (often called the "Stark Law"), which has not been significantly updated since it was enacted in 1989. The proposed rule supports the CMS "Patients over Paperwork" initiative by reducing unnecessary regulatory burden on physicians and other health care providers while reinforcing the Stark Law's goal of protecting patients from unnecessary services and being steered to less convenient, lower quality, or more expensive services because of a physician's financial self-interest. Through the Patients over Paperwork initiative, the proposed rule opens additional avenues for physicians and other health care providers to coordinate the care of the patients they serve - allowing providers across different health care settings to work together to ensure patients receive the highest quality of care.

For More information:

- Proposed Rule: Public comments due by December 31
- Press Release

See the full text of this excerpted CMS Fact Sheet (Issued October 9).

MLN Connects - October 10, 2019

MLN Connects - New Medicare Card: 80% of Claims Submitted with MBI

MLN Connects® for Thursday, October 10, 2019
View this edition as a PDF

News

- New Medicare Card: 80% of Claims Submitted with MBI
- Nursing Homes: Enhancing Transparency about Abuse and Neglect
- Quality Payment Program: MIPS Dates and Deadlines
- October is National Breast Cancer Awareness Month

Compliance

- Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims

Claims, Pricers & Codes

- FY 2020 IPPS and LTCH PPS Claims Hold

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast - November 5

MLN Matters® Articles

- Ambulance Inflation Factor for Calendar Year (CY) 2020 and Productivity Adjustment
- Provider Enrollment Rebuttal Process
- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) - Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage

Determination (NCDs) - January 2020 Update - Revised
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020 - Revised

Publications

- Medicare Preventive Services - Revised
- Medicare Enrollment for Providers Who Solely Order or Certify - Reminder
- Medicare Fraud & Abuse Poster - Reminder
- Medicare Fraud & Abuse: Prevent, Detect, Report - Reminder
- Medicare Overpayments - Reminder
- PECOS for DMEPOS Suppliers - Reminder
- PECOS for Physicians and NPPs - Reminder
- PECOS for Provider and Supplier Organizations - Reminder

Multimedia

- Opioid Treatment Program Listening Session: Audio Recording and Transcript

MLN Connects - October 17, 2019

MLN Connects - New Medicare Card: MBI Transition Ends in Less Than 10 Weeks

MLN Connects® for Thursday, October 17, 2019
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News

- New Medicare Card: MBI Transition Ends in Less Than 10 Weeks
- Guide for Appropriate Tapering or Discontinuation of Long-Term Opioid Use
- ICD-10 Coordination and Maintenance: Deadline for Comments November 8
- CMS Health Equity Award: Submit Nomination by November 15
- Quality Payment Program: Participation Status Tool Includes Second Snapshot of Data
- Atherectomy: Comparative Billing Report in October
- Protect Your Patients from Influenza this Season

Compliance

- Cardiac Device Credits: Medicare Billing

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast - November 5
- Atherectomy: Comparative Billing Report Webinar - November 6
- Provider Compliance Focus Group Meeting - November 12

MLN Matters® Articles

- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS
- Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes
- Home Health Orders for Nurse Practitioners under the Maryland Total Cost of Care (TCOC) Model
- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) - Revised
- October 2019 Update of the Ambulatory Surgical Center (ASC) Payment System - Revised
- October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) - Revised

Publications

- Quality Payment Program: MIPS and APM Resources
- Roster Billing for Mass Immunizers - Revised
- Acute Care Inpatient Hospital Prospective Payment System - Reminder
- Hospice Payment System - Reminder
- Hospital Outpatient Prospective Payment System - Reminder

- Inpatient Psychiatric Facility Prospective Payment System - Reminder
- Inpatient Rehabilitation Facility Prospective Payment System - Reminder
- Long-Term Care Hospital Prospective Payment System - Reminder
- Telehealth Services - Reminder

MLN Connects - October 24, 2019

MLN Connects - New Medicare Card: Claim Reject Codes After January 1

MLN Connects® for Thursday, October 24, 2019
View this edition as a PDF

News

- New Medicare Card: Claim Reject Codes After January 1
- Take Medicare Fraud, Waste and Abuse Fighting Further, Through Innovation
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Compliance

- Proper Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing

Claims, Pricers & Codes

- ICD-10 Vaping Coding Guidance

Events

- Submitting Your Medicare Part A Cost Report Electronically Webcast - November 5
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call - November 14

MLN Matters® Articles

- Updating Calendar Year (CY) 2020 Medicare Diabetes Prevention Program (MDPP) Payment Rates

Multimedia

- CDC Opioids Training Module for Nurses
- Quality Payment Program: APMs Web-Based Training

MLN Connects Special Edition - October 31, 2019

Final Payment Rules for HH, ESRD, and DMEPOS

HHAs: CY 2020 Payment and Policy Changes and CY 2021 Home Infusion Therapy Benefit

CMS issued a final rule with comment period that finalizes routine updates to the home health payment rates for CY 2020, in accordance with existing statutory and regulatory requirements. This rule with comment period includes:

- Modification to the payment regulations pertaining to the content of the home health plan of care
- Allows therapist assistants to furnish maintenance therapy
- Finalizes policies related to the split percentage payment approach under the Home Health Prospective Payment System (HH PPS)
- Final policies related to the implementation of the permanent home infusion therapy benefit in CY 2021, including payment categories, amounts, and required and optional adjustments, and solicits comments on options to enhance future efforts to improve policies related to coverage of eligible drugs for home infusion therapy
- Implementation of the Patient-Driven Groupings Model (PDGM), an alternate case-mix adjustment methodology with a 30-day unit of payment, mandated by the Bipartisan Budget Act of 2018 (BBA of 2018)

CMS projects that aggregate Medicare payments to Home Health Agencies (HHAs) in CY 2020 will increase by 1.3 percent, or $250 million. This increase reflects the effects of the 1.5 percent home health payment update percentage ($290 million increase), mandated by the BBA of 2018; and a 0.2 percent aggregate decrease (-$40 million) in payments to HHAs due to the

changes in the rural add-on percentages, also mandated by the BBA of 2018. The rate updates also include a budget-neutral adjustment to the CY 2020 30-day payment amount to offset anticipated provider behavior changes upon implementation of the PDGM; the use of updated wage index data for the home health wage index; and updates to the fixed-dollar loss ratio to determine outlier payments. Given the scale of the PDGM payment system changes for CY 2020, it may take HHAs more time before they fully implement the behavior assumed by CMS; therefore, we applied the three previously outlined behavior change assumptions to half of the 30-day periods in our analytic file, resulting in a smaller adjustment to the 30-day payment amount needed to maintain budget neutrality, as required by law. CMS is finalizing a CY 2020 30-day payment amount (for those HHAs that report the required quality data) of $1,864.03.

The final rule also includes:

- Enhance and modernize program integrity while reducing regulatory burden
- Paraprofessional roles - Improving access to care
- Home Health Quality Reporting Program
- Home Health Value-Based Purchasing (HHVBP) Model

For More Information:

- Final Rule
- Press Release
- HH PPS website
- HHA Center website
- PDGM webpage
- Home Infusion Therapy Services website
- Home Health Quality Reporting Requirements webpage
- HHVBP Model webpage

See the full text of this excerpted CMS Fact Sheet (Issued October 31).

ESRD and DMEPOS CY 2020 Final Rule

On October 31, CMS issued a final rule that updates payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2020. This rule also updates the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI and finalizes changes to the ESRD Quality Incentive Program.

In addition, this rule includes:

- Methodology for calculating fee schedule payment amounts for new Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items and services and making adjustments to the fee schedule amounts established using supplier or commercial prices if such prices decrease within five years of establishing the initial fee schedule amounts
- Revises existing policies related to the competitive bidding program for DMEPOS
- Streamlines the requirements for ordering DMEPOS items and creates one Master List of DMEPOS items that could potentially be subject to face-to-face encounter and written order prior to delivery and/or prior authorization requirements
- Summaries of responses to requests for information on data collection resulting from the ESRD PPS technical expert panel, possible updates and improvements to the ESRD PPS wage index, and new rules for the competitive bidding of diabetic testing strips

CMS projects that the updates for CY 2020 will increase the total payments to all ESRD facilities by 1.6 percent compared with CY 2019. For hospital-based ESRD facilities, CMS projects an increase in total payments of 2.1 percent, while for freestanding facilities, the projected increase in total payments is 1.6 percent.

The final rule also includes:

- Update to the outlier policy
- Eligibility criteria for the Transitional Drug Add-on Payment Adjustment (TDAPA)
- Basis of payment for the TDAPA for calcimimetics
- Average sales price conditional policy for the application of the TDAPA
- New and innovative renal dialysis equipment and supplies

- Discontinuing the erythropoiesis-stimulating agent monitoring policy
- Requests for Information

For More Information:

- Final Rule
- Press Release

See the full text of this excerpted CMS Fact Sheet (Issued October 31).

MLN Connects Special Edition - November 1, 2019

Physician Fee Schedule: Finalized Policy, Payment, and Quality Provisions for CY 2020

On November 1, CMS issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) effective on or after January 1, 2020.

Payment Provisions:

- Ratesetting and conversion factor
- Medicare telehealth services
- Evaluation and management services
- Physician supervision requirements for physician assistants
- Review and verification of medical record documentation
- Care management services
- Medicare coverage for opioid use disorder treatment services furnished by opioid treatment programs
- Bundled payments under the PFS for opioid use disorders
- Therapy services

Other Provisions:

- Quality Payment Program
- Ambulance services
- Ground ambulance data collection system
- Open Payments Program
- Medicare Shared Savings Program

For More Information:

- Final Rule
- Press Release
- Press Release - Treatment for Opioid Use Disorder
- Quality Payment Program Fact Sheet
- Register for November 6 Call

See the full text of this excerpted CMS Fact Sheet (Issued November 1).

Medicare Hospital OPPS and ASC Payment System Final Rule for CY 2020

On November 1, CMS finalized policies that aim to increase choices, encourage medical innovation, empower patients, and eliminate waste, fraud, and abuse to protect seniors and taxpayers. The changes build on existing efforts to increase patient choice by making Medicare payment available for more services in different sites of services and adopting policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

In accordance with Medicare law, CMS is updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.6 percent. This update is based on the projected hospital market basket increase of 3.0 percent minus a 0.4 percentage point adjustment for Multi-Factor Productivity (MFP).

Using the hospital market basket, CMS is finalizing an update to the ASC rates for CY 2020 equal to 2.6 percent. The update applies to ASCs meeting relevant quality reporting requirements. This change is based on the projected hospital market basket

increase of 3.0 percent minus a 0.4 percentage point adjustment for MFP. This change will also help to promote site-neutrality between hospitals and ASCs and encourage the migration of services from the hospital setting to the lower cost ASC setting.

The final rule with comment period includes:

- Increasing choices and encouraging site neutrality
- Method to control for unnecessary increases in utilization of outpatient services
- Changes to the inpatient only list
- ASC covered procedures list
- Payment for procedures involving skin substitutes
- Rethinking rural health
- Changes in the level of supervision of outpatient therapeutic services in hospitals and critical access hospitals
- Addressing wage index disparities
- Unleashing innovation
- Device pass-through applications
- Protecting taxpayer dollars
- Meaningful Measures/Patients Over Paperwork
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program
- OPPS payment methodology for 340B purchased drugs
- Partial Hospitalization Program (PHP) rate setting
- Update to PHP per diem rates
- Revision to the organ procurement organization conditions for certification

For More Information:

- Final Rule
- Register for November 6 Call

See the full text of this excerpted CMS Fact Sheet (Issued November 1).

MLN Connects Special Edition - November 4, 2019

Physician Fee Schedule and OPPS/ASC Final Rules Call - November 6

Wednesday, November 6 from 2:15 to 3:45 pm ET

Register for Medicare Learning Network events.

During this call, learn about the provisions in two CMS CY 2020 final rules:

- Physician Fee Schedule and Quality Payment Program: Final Rule, Press Release, Physician Fee Schedule Fact Sheet, and Quality Payment Program Fact Sheet
- Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment systems: Final Rule and Fact Sheet

Changes to the Physician Fee Schedule are aimed at reducing burden, recognizing clinicians for the time they spend taking care of patients, removing unnecessary measures, and making it easier for clinicians to be on the path towards value-based care. Topics include:

- Payment and supervision policy updates
- Merit-based Incentive Payment System Value Pathways: Streamlining the Quality Payment Program to reduce clinician burden
- Creating the new Opioid Treatment Program benefit in response to the opioid epidemic

In addition, updates and policy changes under the Medicare OPPS and ASC payment systems lay the foundation for a patient-driven health care system.

A question and answer session follows the presentation. We encourage you to review the final rules prior to the call.

Target Audience: Medicare Part B fee-for-service clinicians; office managers and administrators; state and national associations that represent health care providers; all hospitals operating in the United States; and other stakeholders.

MLN Connects - November 7, 2019

MLN Connects - New Medicare Card: HICN Claims Reject January 1, 2020

MLN Connects® for Thursday, November 7, 2019
View this edition as a PDF

News

- New Medicare Card: HICN Claims Reject January 1, 2020
- IRF/LTCH/SNF Quality Reporting Program: Submission Deadline Extended to November 18
- MIPS Heart Failure Measure: Call for Public Comment Closes November 27
- CAHs: Hardship Exception Application Deadline December 2
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- MIPS: Virtual Group Election Period Open Through December 31
- Medicare Ground Ambulance Data Collection System: Starts January 1, 2020
- Home Health Agency: Final OASIS D-1 Data Submission Specifications
- MACRA Patient Relationship Categories and Codes: Learn More
- Recommend Influenza Vaccination: Each Office Visit is an Opportunity

Compliance

- Bill Correctly for Medicare Telehealth Services

Claims, Pricers & Codes

- Skilled Nursing Facility Claims Hold

Events

- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call - November 14
- Ground Ambulance Organizations: Data Collection System Call - December 5

MLN Matters® Articles

- Addition of Medical Severity Diagnosis Related Groups (MS-DRG) Subject to Inpatient Prospective Payment System (IPPS) Replaced Devices Offered Without Cost or With a Credit Policy
- Health Professional Shortage Area (HPSA) Bonus Payments for All Mental Health Specialties
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.0, Effective January 1, 2020
- April 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) - Revised
- Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System - Revised

Publications

- Opioid Treatment Programs (OTPs) Medicare Enrollment
- Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B - Revised

Multimedia

- Medicare Telehealth Services Video

MLN Connects Special Edition - November 12, 2019

HICN Claims Reject

We are 50 days out from the end of the Medicare Beneficiary Identifier (MBI) transition period. Use the MBI on Medicare claims and other transactions now. Starting January 1, regardless of the date of service:

- We will reject claims submitted with Health Insurance Claim Numbers (HICNs) with a few exceptions
- We will reject all eligibility transactions submitted with HICNs

See the MLN Matters Article to learn how to get and use MBIs.

MLN Connects - November 14, 2019

MLN Connects - New Medicare Card: If an MBI Changes

MLN Connects® for Thursday, November 14, 2019
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News

- New Medicare Card: If an MBI Changes
- Medicare Shared Savings Program: Application Deadlines for January 1, 2021, Start Date
- Drug Units in Excess of MUE: Comparative Billing Report in November
- Person-Centered Planning: Comment on Performance Measurement by December 2
- Emergency Preparedness Resources
- Raising Awareness of Diabetes in November
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Compliance

- Skilled Nursing Facility 3-Day Rule Billing

Claims, Pricers & Codes

- MACRA Patient Relationship Categories and Codes: Reporting HCPCS Level II Modifiers

Events

- Kidney Care Choices Model Webinars - November 15 and 22
- 2020 Quality Payment Program Final Rule Webinar - November 19
- Drug Units in Excess of MUE: Comparative Billing Report Webinar - December 4
- Ground Ambulance Organizations: Data Collection System Call - December 5

MLN Matters® Articles

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - April 2020 Update
- Updates to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)
- Display PARHM Claim Payment Amounts - Revised
- October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) - Revised
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update - Revised

MLN Connects Special Edition - November 15, 2019

Hospital Price Transparency Requirements

CY 2020 Hospital Outpatient Prospective Payment System Policy Changes

On November 15, CMS finalized policies that lay the foundation for a patient-driven health care system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services.

The policies in the final rule will further advance the agency's commitment to increasing price transparency. It includes requirements that would apply to each hospital operating in the United States. In response to comments, CMS is extending the effective date to January 1, 2021 to ensure hospital compliance with these regulations.

The final rule includes:

- Definitions of "hospital," "standard charges," and "items and services"
- Requirements for making public all standard charges for all items and services in a machine-readable format
- Requirements for displaying shoppable services in a consumer-friendly manner
- Monitoring and enforcement

For More Information:

- View the final rule (CMS-1717-F2): This HHS-approved document has been submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the Federal Register. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. The document published in the Federal Register is the official HHS-approved document.
- Press Release
- Registration opening soon for December 3 Call

See the full text of this excerpted CMS Fact Sheet (Issued November 15).

MLN Connects Special Edition - November 19, 2019

New Medicare Card: Get Paid January 1, 2020 - Use MBIs Now

Do not wait. Update your patients' records and use Medicare Beneficiary identifiers (MBIs) now, before you are busy with other patient insurance changes in January.

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based number; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in English (or Spanish).
- Use your Medicare Administrative Contractor's look-up tool. Sign up for the Portal to use the tool.
- Check the remittance advice. Until December 2019, we return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number (HICN).

Starting January 1, you must use MBIs to bill Medicare regardless of the date of service:

- We will reject claims submitted with HICNs with a few exceptions
- We will reject all eligibility transactions submitted with HICNs

See the MLN Matters Article for answers to your questions on using MBIs.

MLN Connects - November 21, 2019

MLN Connects - Hospital Price Transparency: Register for Dec 3 Call

MLN Connects® for Thursday, November 21, 2019
View this edition as a PDF

News

- Promoting Interoperability Programs: Updated list of eCQMs
- MIPS Improvement Activities Technical Expert Panel: Nominations due November 29
- DMEPOS Competitive Bidding Surveys: Comment by December 20
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Modernizing CMS: Organizational Changes Announced

Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- Hospital Price Transparency Final Rule Call - December 3
- Hospice Quality Reporting Program Forum Webinar - December 4
- Ground Ambulance Organizations: Data Collection System Call - December 5

MLN Matters® Articles

- 2020 Annual Update to the Therapy Code List
- 2020 Annual Update of Per-Beneficiary Threshold Amounts
- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020
- Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions
- Medicare Physician Fee Schedule Database (MPFSDB) Update to Status Indicators
- Positron Emission Tomography (PET) Scan - Allow Tracer Codes Q9982 and Q9983 in the Fiscal Intermediary Shared System (FISS)
- Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2020

Publications

- Medical Privacy of Protected Health Information - Revised
- Remittance Advice Resources and FAQs - Revised

Multimedia

- Part A Cost Report Webcast: Audio Recording and Transcript
- Improving Health Care Quality for LGBTQ People Web-Based Training Course - Updated

MLN Connects Special Edition - November 26, 2019

New Medicare Card: Claim Reject Codes After January 1

Get paid. Use Medicare Beneficiary Identifiers (MBIs) now.

If you do not use MBIs on claims (with a few exceptions) after January 1, you will get:

- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based numbers; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in English (PDF) or Spanish (PDF).
- Use your Medicare Administrative Contractor's look-up tool. Sign up for the Portal to use the tool.
- Check the remittance advice. Until the end of December, we return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number.

See the MLN Matters Article to learn how to get and use MBIs.

MLN Connects - November 27, 2019

Patients Over Paperwork Newsletter

MLN Connects® for Wednesday, November 27, 2019
View this edition as a PDF

News

- FY 2019 Medicare FFS Improper Payment Rate Lowest Since 2010
- Patients Over Paperwork Newsletter
- Celebration of National Rural Health Day
- November is Home Care and Hospice Month
- World AIDS Day is December 1

Compliance

- Ambulance Fee Schedule and Medicare Transports

Events

- Hospital Price Transparency Final Rule Call - December 3
- Ground Ambulance Organizations: Data Collection System Call - December 5

MLN Matters® Articles

- Home Health Agencies (HHAs) Urged to Establish Access to the Internet Quality Improvement and Evaluation System (iQIES) By December 23, 2019
- Claim Status Category and Claim Status Codes Update
- Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2020
- 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
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2020
- Updating Fiscal Intermediary Shared System (FISS) Editing for Practice Locations to Bypass Mobile Facility and/or Portable Units and Services Rendered in the Patient's Home
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020 - Revised

Publications

- Quality Payment Program: MIPS and APM Resources
- ACOs: Beneficiary Engagement Toolkit and Case Studies

Multimedias

- Physician Fee Schedule and Hospital OPPS/ASC Call: Audio Recording and Transcript

Insulin and Non-insulin Dependent Billing Requirements

The KX or KS modifier must be added to blood glucose and continuous glucose monitors as well as related supplies, depending on whether the beneficiary is being treated with insulin. If the beneficiary is being treated with insulin injections, the KX modifier must be added to the code for the monitor and each related supply on every claim submitted to Medicare. If the beneficiary is not being treated with insulin injections, the KS modifier must be used. Noridian's Medical Review and Redeterminations staff are seeing frequent billing errors due to the incorrect use of these modifiers. For proper payment, the correct modifier must to be submitted on each claim.

- KS Modifier - Glucose monitor supply for diabetic beneficiary not treated with insulin
- KX Modifier - Glucose monitor supply for diabetic beneficiary treated with insulin

Modifier Tool Now Available to Avoid Denials

Noridian has developed a website tool that helps suppliers determine which modifiers are applicable for the HCPCS billed. This assists in avoiding claim denials and/or rejections while also offering insight into applicable pricing or informational modifiers. Suppliers who receive the following Reason and Remark Codes on their remittance advices will benefit by using this tool and sharing it within their office.

- Reason Code 4, Remark code N519 - HCPCS code is inconsistent with modifier used or required modifier is missing
- Reason Code 50, Remark Code N115 - Item billed may require a specific diagnosis or modifier code based on related Local Coverage Determination (LCD)

An example of the tool depicts the HCPCS entered, the applicable modifiers to consider based on the circumstance, and resources for further research.

The Modifier Look-up Tool can be accessed from either the Education and Outreach / Tools section or from the Browse by Topic / Modifiers / Educational Resources section of our website.

RA Modifier: Be Sure to Use Correctly

There are only certain circumstances in which suppliers should append modifier RA (Replacement of a DME, Orthotic or Prosthetic Item). View the Modifier RA webpage to learn about the correct use, the exceptions, incorrect use, and resources available.

NMP: Part B Deductible, Hospice, and MDPP Response Expansion

The Noridian Medicare Portal (NMP) information returned within the eligibility inquiry responses has been updated to include expanded deductible information for multiple years, more comprehensive hospice episodes, and Medicare Diabetes Prevention Program (MDPP) service periods.

Part B Deductible

An Eligibility inquiry will now return Part B deductible information for all benefit periods included in the date of service entered in the inquiry. For example, when using the default date of service range, 12 months in the past and four months in the future based on the current date, the portal will return deductible information for benefit periods 2018, 2019 and 2020 (when available). In addition, a Qualified Medicare Beneficiary (QMB) enrolled indicator will provide if the beneficiary was a QMB enrollee during that benefit period.

Hospice

All applicable hospice episodes for the beneficiary will be returned regardless of the dates of service entered in the Eligibility inquiry.

Medicare Diabetes Prevention Program (MDPP)

The MDPP is available for a minimum of 12 months and a maximum of 24 months. The maximum service period is determined by the end date of Period 2. The MDPP section of an Eligibility will now include this Period 2 End Date. This will ensure no active MDPP periods are returned after the maximum service period date.

Resources

- Noridian Medicare Portal
- NMP Education on Demand Tutorials

DMEPOS Nationwide Expansion of Required PA of Pressure Reducing Support Surfaces

A Federal Register Notice (84 FR 16616) added five Pressure Reducing Support Surfaces codes to the Required Prior Authorization (PA) List. Effective October 21, all Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers in all states are required to obtain prior authorization for these items:

- E0193 - Powered air flotation bed (low air loss therapy)
- E0277 - Powered pressure-reducing air mattress
- E0371 - Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width
- E0372 - Powered air overlay for mattress, standard mattress length and width
- E0373 - Non-powered advanced pressure reducing mattress

Visit the Prior Authorization Process for Certain DMEPOS Items webpage for more information, including the June 4, 2019 Open Door Forum Slides, and PA Operational Guide.

Source: CMS MLN Connects dated August 29, 2019

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - January 2020

MLN Matters Number: MM11495
Related CR Release Date: September 27, 2019
Related CR Transmittal Number: R4404CP
Related Change Request (CR) Number: 11495
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

CR11495 informs MACs about new and revised Average Sales Price (ASP) and ASP Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. The Centers for Medicare & Medicaid Services (CMS) will make files available for download on or after December 16, 2019. CMS gives MACs the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions available in Chapter 4, Section 50 of the Medicare Claims Processing Manual found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf. Make sure that your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11495.

Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM11467
Related CR Release Date: November 15, 2019
Related CR Transmittal Number: R4460CP
Related Change Request (CR) Number: 11467
Effective Date: April 1, 2020
Implementation Date: April 6, 2020

CR 11467 updates 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. Make sure your billing staff is aware of this update.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11467

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: MM11490
Related CR Release Date: November 15, 2019
Related CR Transmittal Number: R4463CP
Related Change Request (CR) Number: 11490
Effective Date: April 1, 2020
Implementation Date: April 6, 2020

CR 11490 instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (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 CORE Code Combination List scheduled to be published on or about February 1, 2020. Make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11490

HCPCS Codes for SNF CB Update - 2020 Annual Update

MLN Matters Number: MM11441
Related CR Release Date: August 30, 2019
Related CR Transmittal Number: R4385CP
Related Change Request (CR) Number: 11441
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

CR 11441 makes changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule (MPFS) designations that will be used to revise Medicare's Common Working File (CWF) edits to allow MACs to make appropriate payments in accordance with policy for Skilled Nursing Facility (SNF) Consolidated Billing (CB) in Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6 in the Medicare Claims Processing Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf). Make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11441.

HCPCS Drug/Biological Code Changes - October 2019 Update - Revised

MLN Matters Number: MM11422 Revised
Related CR Release Date: November 4, 2019
Related CR Transmittal Number: R4443CP
Related Change Request (CR) Number: 11422
Effective Date: October 1, 2019
Implementation Date: October 7, 2019

Note: CMS revised this article on November 5, 2019, to reflect the revised CR11422 issued on November 4, 2019. The revised CR added HCPCS code J0642, and CMS added that code in the article. Also, CMS revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

CR 11422 updates the Healthcare Common Procedure Coding System (HCPCS) code set for codes related to drugs and biologicals. Make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11422.

Quarterly Update for the Temporary Gap Period of the DMEPOS CBP - January 2020

MLN Matters Number: MM11462
Related CR Release Date: September 20, 2019
Related CR Transmittal Number: R4397CP
Related Change Request (CR) Number: 11462
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

Medicare updates the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) files on a quarterly basis to implement necessary changes to the Healthcare Common Procedure Coding System (HCPCS), ZIP code, and supplier files. CR11462 provides specific instruction for implementing the DMEPOS CBP files.

The Round 1 2017, Round 2 Recompete, and National Mail Order (NMO) Recompete CBP contracts expired on December 31, 2018. Due to a delay in the announcement of the next round of the CBP, contracts are not in effect in Round 1, Round 2, or the NMO Competitive Bidding Areas (CBAs) as of January 1, 2019, resulting in a temporary gap period in the CBP.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11462.

Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

MLN Matters Number: MM11489
Related CR Release Date: November 15, 2019
Related CR Transmittal Number: R4461CP
Related Change Request (CR) Number: 11489
Effective Date: April 1, 2020
Implementation Date: April 6, 2020

CR 11489 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes and obtain the updated MREP and PC Print if they use that software

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11489

Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2020

MLN Matters Number: MM11542
Related CR Release Date: November 22, 2019
Related CR Transmittal Number: R129GI
Related Change Request (CR) Number: 11542
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

CR 11542 instructs the MACs to update the claims processing system with the new Calendar Year (CY) 2020 Medicare rates. These updates relate to Chapter 3, sections 10.3, 20.2, and 20.6 of the Medicare General Information, Eligibility, and Entitlement Manual, which are attachments to the CR. Please make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11542.