DME Happenings

Jurisdiction D

June 2020

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COVERAGE

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

Don't be left in the dark, sign up for the Noridian e-mail listing to receive updates that contain the latest Medicare news. Visit the Noridian website and select "Subscribe" on the bottom right-hand corner of any page.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index

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Healthcare Solutions

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions LLC

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Phone Numbers

Department/System	Phone Number	Availability
Interactive Voice Response System (IVR)	877-320-0390	24/7 for Eligibility 6 a.m. - 8 p.m. CT for all other inquiries
Supplier Contact Center	877-320-0390	Monday - Friday 8 a.m. - 6 p.m. CT
Telephone Reopenings	877-320-0390	Monday - Friday 8 a.m. - 4:30 p.m. CT
Beneficiary Customer Service	800-633-4227	24/7

Fax Numbers

Department	Fax Number
Reopenings/Redeterminations Recovery Auditor Redeterminations	701-277-7886
Recoupment • Refunds to Medicare • Immediate Offsets	701-277-7894
MSP Refunds	701-277-7892
Recovery Auditor Offsets	701-277-7896
MR Medical Documentation	701-277-7888

Email Addresses

Correspondence	When to Use This Address	Email Address
Customer Service	Suppliers can submit emails to Noridian for answers regarding basic supplier information regarding Medicare regulations and coverage	See webpage https://med.noridianmedicare.com/web/jddme/contact/email-customer-service
Comprehensive Error Rate Testing (CERT)	Use this address for CERT related inquiries, such as outcomes and status checks. *Include the CID within the message*	jddmecert@noridian.com
Congressional Inquiries or FOIA Requests	Use this address when submitting Freedom of Information Act (FOIA) requests or if the request is coming from a Congressional office. *Emails sent to this address require specific information. Review the Freedom of Information Act or Congressional Inquiries webpages for a full listing of required items to include*	DMEDCongressional.FOIA@noridian.com

Correspondence	When to Use This Address	Email Address
LCD: New LCD Request	Use this address to request the creation of a new LCD. *Emails sent to this address require specific information. Review the New LCD Request Process webpage for a full listing of required items to include*	DMERecon@noridian.com
LCD Reconsideration Request	Use this address to request a revision to an existing LCD. *Emails sent to this address require specific information. Review the LCD Reconsideration Process webpage for a full listing of required items to include*	DMERecon@noridian.com
Recoupment	Use this address to submit requests for immediate offsets of open debt(s)	dmemsprecoupment@noridian.com
Reopenings and Redeterminations	Use this address with questions regarding: Timely Filing Inquiries, Appeal Rights and Regulations, Coverage Questions, Redetermination Documentation Requirements, Social Security Laws, Interpretation of Redetermination Decisions and Policies	dmeredeterminations@noridian.com
Website Questions	Use this form to report website ease of use or difficulties	See webpage https://med.noridianmedicare.com/web/jddme/help/website-feedback
CMS Comments on Noridian	Use this contact information to send comments to CMS concerning Noridian's performance	See webpage https://med.noridianmedicare.com/web/jddme/contact/cotr

Mailing Addresses

Department	Address
• Advance Determination of Medicare Coverage Requests • Claim Submission • Congressional Inquiries • Correspondence • Education • Electronic Funds Transfer (EFT) • Freedom of Information Act (FOIA) • Medical Review Documentation • Overpayment Redetermination and Rebuttal Requests • Recovery Auditor Overpayments • Recovery Auditor Redeterminations • Redetermination Requests • Refunds • Written Reopening Requests	Noridian JD DME Attn: _____ PO Box 6727 Fargo, ND 58108-6727

Department	Address
• Administrative Simplification Compliance Act Exception Requests (ASCA) • Benefit Integrity	Noridian JD DME Attn: _____ PO Box 6736 Fargo, ND 58108-6736
• LCD: New LCD Request • Medical Review - Prior Authorization Requests (PAR)	Noridian JD DME Attn: _____ PO Box 6742 Fargo, ND 58108-6742
• Extended Repayment Schedule (ERS) • Refund Checks	Noridian JD DME Attn: _____ PO Box 511531 Los Angeles, CA 90051-8086
Qualified Independent Contractor (QIC)	MAXIMUS Federal DME - QIC Project 3750 Monroe Avenue, Suite 777 Pittsford, NY 14534

DME MACs and Other Resources

MAC/Resource	Phone Number	Website
Noridian: Jurisdiction A	866-419-9458	https://med.noridianmedicare.com/web/jadme
Noridian: Jurisdiction D	877-320-0390	https://med.noridianmedicare.com/web/jddme
CGS: Jurisdiction B	877-299-7900	https://www.cgsmedicare.com/
CGS: Jurisdiction C	866-238-9650	https://www.cgsmedicare.com/
Pricing, Data Analysis and Coding (PDAC)	877-735-1326	https://www.dmepdac.com/
National Supplier Clearinghouse	866-238-9652	https://www.palmettogba.com/nsc
Common Electronic Data Interchange (CEDI) Help Desk	866-311-9184	https://www.ngscedi.com
Centers for Medicare and Medicaid Services (CMS)		https://www.cms.gov/

Beneficiaries Call 1-800-MEDICARE

Suppliers are reminded that when beneficiaries need assistance with Medicare questions or claims that they should be referred to call 1-800-MEDICARE (1-800-633-4227) for assistance. The supplier contact center only handles inquiries from suppliers.

The table below provides an overview of the types of questions that are handled by 1-800-MEDICARE, along with other entities that assist beneficiaries with certain types of inquiries.

Organization	Phone Number	Types of Inquiries
1-800-MEDICARE	1-800-633-4227	General Medicare questions, ordering Medicare publications or taking a fraud and abuse complaint from a beneficiary
Social Security Administration	1-800-772-1213	Changing address, replacement Medicare card and Social Security Benefits
RRB - Railroad Retirement Board	1-800-808-0772	For Railroad Retirement beneficiaries only - RRB benefits, lost RRB card, address change, enrolling in Medicare
Coordination of Benefits - Benefits Coordination & Recovery Center (BCRC)	1-855-798-2627	Reporting changes in primary insurance information

Another great resource for beneficiaries is the website, https://www.medicare.gov/, where they can:

- Compare hospitals, nursing homes, home health agencies, and dialysis facilities
- Compare Medicare prescription drug plans
- Compare health plans and Medigap policies
- Complete an online request for a replacement Medicare card
- Find general information about Medicare policies and coverage
- Find doctors or suppliers in their area
- Find Medicare publications
- Register for and access MyMedicare.gov

As a registered user of MyMedicare.gov, beneficiaries can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card
- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

“This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.”

Sources for “DME Happenings” Articles

The purpose of “DME Happenings” is to educate Noridian’s Durable Medical Equipment supplier community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever Noridian publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes “Source” following CMS derived articles to allow for those interested in the original material to research it at CMS’s website, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled "MLN Matters", which will continue to be published in Noridian bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

CMS Quarterly Provider Updates

The Quarterly Provider Update is a listing of non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers or suppliers. This comprehensive resource is published by CMS on the first business day of each quarter. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs ad complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index. Suppliers may also sign up to receive notification when regulations and program instructions are added throughout the quarter on this page.

Physician Documentation Responsibilities

Suppliers are encouraged to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity (CMN). It is the physician's and supplier's responsibility to determine the medical need for, and the utilization of, all health care services. The physician and supplier should ensure that information relating to the beneficiary's condition is correct. Suppliers are also encouraged to include language in their cover letters to physicians reminding them of their responsibilities.

Source: CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.3.2

Automatic Mailing/Delivery of DMEPOS Reminder

Suppliers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS.

A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore, the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. Again, the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

Source: Internet Only Manual (IOM), Publication 100-4, Medicare Claims Processing Manual, Chapter 20, Section 200

Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Overpayment Refund Form found on the Forms page of the Noridian DME website. This form provides Medicare with the necessary information to process the refund properly. This is

an interactive form which Noridian has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Overpayment Refund Form instructions.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, Medicare number or claim number information is not provided, no appeal rights can be afforded.

Suppliers are also reminded that "The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

Source: Transmittal 50, Change Request 3274, dated July 30, 2004

Change to Resubmission Request Responses for Prior Authorization of PMD

Beginning April 13, 2020 resubmission requests for the Prior Authorization of Power Mobility Devices (PMDs) will be completed in 10 business days. As a result, decisions will be issued in 10 business days for initial submissions and resubmissions. Decisions for expedited submissions will still be issued in two business days.

New Accelerated/Advance Payment Request Form

CMS has provided a standard form for requesting accelerated or advance payments, which can be found on the Noridian COVID-19 web pages and on the Forms web page within the Refunds and Overpayment section.

We encourage providers to use this new form as it contains all the information needed on one page. The new form also allows for submission of multiple PTAN/NPI requests in certain cases to speed up the request process. See the form for instructions and more details.

If you have questions on completion of the forms or the process, call the COVID-19 hotline at 866-575-4067 Monday-Friday from 8 a.m.-6 p.m. CDT.

New Physician Specialty Code for Micrographic Dermatologic Surgery (MDS) and Adult Congenital Heart Disease (ACHD) and a New Supplier Specialty Code for Home Infusion Therapy Services

MLN Matters Number: MM11750
Related CR Release Date: May 8, 2020
Related CR Transmittal Numbers: R10124CP and R10124FM
Related Change Request (CR) Number: 11750
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

CR 11750 article informs you of new physician specialty codes for Micrographic Dermatologic Surgery (MDS) (D7), and Adult Congenital Heart Disease (ACHD) (D8), and a new supplier specialty code for Home Infusion Therapy Services (D6). Make sure that your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11750.

Oxygen and Infusion Pumps: CGS and Noridian COVID-19 Claims that were Submitted Without a Certificate of Medical Necessity or DME MAC Information Form (DIF) and Denied

With the recent COVID-19 Public Health Emergency (PHE), the Centers for Medicare & Medicaid Services (CMS) is allowing Medicare beneficiaries to obtain DME oxygen equipment without a Certificate of Medical Necessity (CMN) for oxygen and without a DME MAC Information Form (DIF) for external infusion pumps.

This includes claims affected by the COVID-19 PHE and is for claims for dates of service beginning March 1, 2020 through the duration of the PHE.

The claim should be submitted with CR modifier and COVID-19 as the narrative.

If the claim is denied due to a missing CR modifier or narrative these claims can be corrected with Noridian and CGS as Written Reopenings. Noridian will also accept these claims through Telephone Reopenings.

RELATED HCPCS

- Oxygen: E0424, E0425, E0430, E0431, E0433-E0435, E0439, E0440-E0447, E1390-E1392, E1405, E1406, K0738
- Infusion Pumps: E0779-E0781, E0784, E0787, E0791, E1399, K0455

Provider Compliance Tips for Nebulizers and Related Drugs Fact Sheet - Revised

A revised Provider Compliance Tips for Nebulizers and Related Drugs Medicare Learning Network Fact Sheet is available. Learn about:

- Coverage requirements
- Documentation
- How to prevent claim denials

Provider Compliance Tips for Nebulizers and Related Drugs

Section 4.26.2 in Chapter 4 of Publication (Pub.) 100-08

Related CR Release Date: March 06, 2020
Related CR Transmittal Number: R944PI
Related Change Request (CR) Number: 11541
Effective Date: April 6, 2020
Implementation Date: April 6, 2020

The purpose of this Change Request (CR) is to re-insert a paragraph in section 4.26.2 in chapter 4 of Pub. 100-08 that was deleted in error. The paragraph permits a supplier to deliver a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) item to the patient's home approximately two (2) days prior to the patient's anticipated discharge.

View the complete CMS Transmittal (CR)11541.

Self-Service Required Use for Telephone Reopenings - Effective June 1, 2020

Effective June 1, 2020, Noridian will require suppliers to use the Noridian Medicare Portal (NMP) for all reopenings that are available through the self-service reopening. Until then, Customer Service Representatives (CSRs) will educate callers on this functionality. If it is found that the reason for the telephone reopening request can be completed in the self-service option, the CSR will direct the caller back out to use this option.

Specifics about self-services reopenings can be found within the Noridian Medicare Portal Guide.

The CMS Internet Only Manual (IOM), Publication 100-09, Chapter 6, Section 50 mandates that all providers first access inquiries through self-service technology,".... One important way to successfully manage the provider inquiry workload is to increase and enhance the self-service technology tools available to Medicare providers and to require providers to use these tools when appropriate."

This process change will allow Noridian to meet CMS requirements and our CSRs to assist callers with more complex reopenings which cannot be completed through the self-service tool.

CSRs are still able to assist with callers with the below telephone reopening categories as they are not currently available through the self-service reopening function. **Note:** List is not all inclusive.

- Loading Beneficiary Owned Equipment
- Correcting the Referring Physician's Name
- Correcting the Referring Physician's National Provider Identifier (NPI)
- Claims that were rejected during the Self-Service Reopening process

Value-Based Insurance Design (VBID) Model - Implementation of the Hospice Benefit Component

MLN Matters Number: MM11754
Related CR Release Date: May 8, 2020
Related CR Transmittal Number: R10127DEMO
Related Change Request (CR) Number: 11754
Effective Date: January 1, 2021
Implementation Date: October 5, 2020

CR 11754 is for hospice care and other providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries who have elected hospice and are enrolled in Medicare Advantage (MA) plans participating in the voluntary Value-Based Insurance Design (VBID) Model's hospice benefit component.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11754.

Telephone Reopenings: Resources for Success

This article provides the following information on Telephone Reopenings: contact information, hours of availability, required elements, items allowed through Telephone Reopenings, those that must be submitted as a redetermination, and more.

Per the CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 34, Section 10, reopenings are separate and distinct from the appeals process. Contractors should note that while clerical errors must be processed as reopenings, all decisions on granting reopenings are at the discretion of the contractor.

Section 10.6.2 of the same Publication and Chapter states a reopening must be conducted within one year from the date of the initial determination.

Question	Answer
How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-877-320-0390.
What are the hours for Telephone Reopenings?	Monday - Friday 8 a.m. - 6 p.m. CT Holiday and Training Closures can be found at https://med.noridianmedicare.com/web/jddme/contact/holiday-schedule and https://med.noridianmedicare.com/web/jddme/contact/training-closures
What information do I need before I can initiate a Telephone Reopening?	Before a reopening can be completed, the caller must have ***all*** of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed. Verified by Customer Service Representative (CSR) or IVR • National Provider Identifier (NPI) • Provider Transaction Access Number (PTAN) • Last five digits of Tax Identification Number (TIN) Verified by CSR • Caller's name • Provider/Facility name • Beneficiary Medicare number • Beneficiary first and last name • Date of Service (DOS) • Last five digits of Claim Control Number (CCN) • HCPCS code(s) in question • Corrective action to be taken Claims with remark code MA130 can **never** be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

Question	Answer
What may I request as a Telephone Reopening?	The following is a list of clerical errors and omissions that **may** be completed as a Telephone Reopening. Note: This list is not all-inclusive. • Diagnosis code changes or additions • Date of Service (DOS) changes • HCPCS code changes • Certain modifier changes or additions (not an all-inclusive list) If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation.
What is not accepted as a Telephone Reopening?	The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation. • Overutilization denials that require supporting medical records • Certificate of Medical Necessity (CMN) issues (applies to Telephone Reopenings only) • Durable Medical Equipment Information Form (DIF) issues (applies to both Written and Telephone Reopenings) • Oxygen break in service (BIS) issues • Overpayments or reductions in payment. Submit request on Overpayment Refund Form • Medicare Secondary Payer (MSP) issues • Claims denied for timely filing (older than one year from initial determination) • Complex Medical Reviews or Additional Documentation Requests (ADRs) • Change in liability • Recovery Auditor-related items • Certain modifier changes or additions: EY, GA, GY, GZ, K0 - K4, KX, RA (cannot be added), RB, RP • Certain HCPCS codes: E0194, E1028, K0108, K0462, L4210, All HCPCS in Transcutaneous Electrical Nerve Stimulator (TENS) LCD, All National Drug Codes (NDCs), miscellaneous codes and codes that require manual pricing The above is not an all-inclusive list.
What do I do when I have a large amount of corrections?	a supplier has at least 10 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information for the supplier to submit a Special Project.
Where can I find more information on Telephone Reopenings?	• Supplier Manual Chapter 13 • Reopening webpage • CMS IOM, Publication 100-04, Chapter 34
Additional assistance available	Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Emails containing Protected Health Information (PHI) will be returned as unprocessable.

CERT Documentation

This article is to remind suppliers they must comply with requests from the Comprehensive Error Rate Testing (CERT) Documentation Contractor for medical records needed for the CERT program. An analysis of the CERT related appeals workload indicates the reason for the appeal is due to "no submission of documentation" and "submitting incorrect documentation."

Suppliers are reminded the CERT program produces national, contractor-specific and service-specific paid claim error rates, as well as a supplier compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The supplier compliance error rate is a measure of the extent to which suppliers are submitting claims correctly.

The CERT Documentation Contractor sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CERT Documentation Contractor will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT Operations Center via fax, the preferred method, or mail at the number/address specified below.

The secure fax number for submitting documentation to the CERT Documentation Contractor is 804-261-8100.

Mail all requested documentation to:

AdvanceMed
CERT Documentation Center
1510 East Parham Road
Henrico, VA 23228

The CID number is the CERT reference number contained in the documentation request letter.

Suppliers may call the CERT Documentation Contractor at 888-779-7477 with questions regarding specific documentation to submit.

Suppliers must submit medical records within 75 days from the receipt date of the initial letter or claims will be denied. The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims.

Also, Medicare patients have already given authorization to release necessary medical information in order to process claims. Therefore, Medicare suppliers do not need to obtain a patient's authorization to release medical information to the CERT Documentation Contractor.

Suppliers who fail to submit medical documentation will receive claim adjustment denials from Noridian as the services for which there is no documentation are interpreted as services not rendered.

Targeted Probe and Educate Review Updates: January 2020 - March 2020

The Jurisdiction D, DME MAC, Medical Review Department is conducting Targeted Probe and Educate (TPE) reviews for the below specialties. The following quarterly edit effectiveness results from January 1, 2020 - March 31, 2020 can be located on our Medical Record Review Results webpage:

- Ankle-Foot Orthosis
- Diabetic Supplies
- External Infusion Pumps
- Enteral Nutrition
- Knee Orthosis
- Oral Anticancer Drugs
- Osteogenesis Stimulators
- Ostomy Supplies
- Oxygen
- Positive Airway Pressure (PAP)

- Respiratory Assist Device (RAD)
- Spinal Orthoses
- Surgical Dressings
- Therapeutic Shoes
- Urological Supplies

Supplier compliance results for all TPE reviews completed from January 1, 2020 - March 31, 2020, included:

- 10-claim preview - 22% compliance
- Round 1 - 59% compliance
- Round 2 - 46% compliance
- Round 3 - 53% compliance
    - CMS referral - 27%

Billing of Part B Drugs to DME MACs During COVID-19 Pandemic - Dispensing Amounts - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Billing of Part B Drugs to DME MACs During COVID-19 Pandemic - Dispensing Amounts - Revised, has been created and published to our website.

View the locally hosted 2020 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

CMS Issues Interim Final Rules with Comment (CMS-1744-IFC & CMS-5531-IFC) - COVID-19 Public Health Emergency - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, CMS Issues Interim Final Rules with Comment (CMS-1744-IFC & CMS-5531-IFC) - COVID-19 Public Health Emergency - Revised, has been created and published to our website.

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- Locate/select article title

Correct Use of the KX Modifier During the COVID-19 PHE

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Correct Use of the KX Modifier During the COVID-19 PHE, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
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- Locate/select article title

External Infusion Pumps Final LCD (L33794) and Response to Comments (RTC) Article Published

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, External Infusion Pumps Final LCD (L33794) and Response to Comments (RTC) Article Published, has been created and published to our website.

View the locally hosted 2020 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

Frequently Asked Questions - Final Rule CMS-1713-F - Standard Written Orders

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Frequently Asked Questions - Final Rule CMS-1713-F - Standard Written Orders, has been created and published to our website.

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- Locate/select article title

Frequently Asked Questions for Standard Written Order

The implementation of the Standard Written Order in January 2020 resulted in a multitude of questions from the supplier community. Suppliers are encouraged to review the Frequently Asked Questions - Final Rule CMS-1713-F - Standard Written Orders article which is available on the Medical Director Articles and Standard Written Order pages of our website.

L3960 - Coding Verification review Requirement

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, L3960 - Coding Verification review Requirement, has been created and published to our website.

View the locally hosted 2020 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

Nebulizers Final LCD (L33370) and Response to Comments (RTC) Article Published - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Nebulizers Final LCD (L33370) and Response to Comments (RTC) Article Published, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
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- Locate/select article title

Required Prior Authorization Suspended for the Duration of the COVID-19 Pandemic - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Required Prior Authorization Suspended for the Duration of the COVID-19 Pandemic, has been created and published to our website.

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- Locate/select article title

Use of CR modifier and "COVID-19" narrative on Specified Claims Due to the COVID-19 PHE

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Use of CR modifier and “COVID-19” narrative on Specified Claims Due to the COVID-19 PHE, has been created and published to our website.

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DME MAC Status During the Coronavirus (COVID-19) Pandemic Webinar - Recorded Encore Presentation

An electronically recorded encore presentation of the live collaborative DME MAC Status During the Coronavirus (COVID-19) Pandemic webinar which was originally presented on April 09, 2020 is now available.

The encore is one hour and fifteen minutes in length and is available 24/7. Topics addressed during the webinar included:

- Part B drugs, advance payment, proof of delivery
- ABN delivery
- Pre and post pay medical review
- Condition of Payment Prior Authorization

Simply enter your name and email address to register and view the presentation at:
https://attendee.gotowebinar.com/recording/3889955996970529805

Enteral Nutrition-DME-On-Demand Tutorials Available

Noridian offers suppliers five self-paced training tutorials to assist them in better understanding Enteral Nutrition. The tutorials include information on coding, coverage criteria, nutrient administration, billing, completing the DME Information Form (DIF) and an Enteral Nutrition Quiz.

DME-on-Demand Tutorials:

- Enteral Nutrition: Coding - 12 minutes
- Enteral Nutrition: Coverage Criteria - 7 minutes
- Enteral Nutrition: Nutrient Administration - 6 minutes
- Enteral Nutrition: Billing - 14 minutes
- Completing the DIF for Enteral Nutrition - 6 minutes
- Enteral Nutrition Quiz

Suppliers are encouraged to attend our webinars and/or to view other tutorials available to assist with proper billing and team member education.

Mobility Assist Equipment (MAE) DME on Demands

Noridian offers several tutorials on Mobility Assist Equipment, such as canes and crutches, manual wheelchairs, walkers, and more.

To view these tutorials, see the DME on Demands webpage.

Open Meeting Recordings and Transcripts - Oxygen & Oxygen Equipment (DL33797), Nebulizers (DL33370), External Infusion Pumps (DL33794) and Urological Supplies (DL33803)

The recordings of the Open Meeting that occurred on January 28, 2020 in Dallas, TX, related to - Oxygen & Oxygen Equipment (DL33797), Nebulizers (DL33370) and External Infusion Pumps (DL33794) have been posted. The recordings and transcripts can be found here.

Orthotics Same or Similar DME-on-Demand Tutorial Available

Noridian offers suppliers a self-paced training tutorial to assist in better understanding the same or similar process with orthotics. The tutorial includes information on the definition of same or similar, how to verify a potential same or similar orthotic, and what to do with a same or similar denial.

DME-on-Demand Tutorial

- Orthotics - Same or Similar - 12 minutes

Suppliers are encouraged to attend our webinars and/or to view other tutorials available to assist with proper billing and team member education.

Parenteral Nutrition- DME-On-Demand Tutorials Available

Noridian offers suppliers five self-paced training tutorials to assist them in better understanding parenteral nutrition. The tutorials include information on completing the DME Information Form (DIF), coverage criteria, billing rules, tube trial, coding and a Parenteral Nutrition Quiz.

DME-on-Demand Tutorials:

- Completing the DIF for Parenteral Nutrition - 5 minutes
- Parenteral Nutrition: Coverage Criteria - 9 minutes
- Parenteral Nutrition: Billing Rules - 6 minutes
- Parenteral Nutrition: Tube Trial - 6 minutes
- Parenteral Nutrition: Coding - 4 minutes
- Parenteral Nutrition Quiz

Suppliers are encouraged to attend our webinars and/or to view other tutorials available to assist with proper billing and team member education.

Standard Documentation Requirement DME on Demands

Noridian offers several tutorials on Standard Documentation Requirements, such as Standard Written Order, Request for Refills, Documentation, Continued Use/Continued Need, and more.

To view these tutorials, see the DME on Demands webpage.

Supplier Education on Use of Upgrades for Multi-Function Ventilators - Revised

MLN Matters Number: SE20012 Revised
Article Release Date: May 29, 2020

Note: CMS revised this article to show that the policy on use of multi-function ventilators, as discussed in the "What You Need to Know" section, is a permanent change.

Medicare's multi-function ventilator policy applies to beneficiaries who are prescribed and meet the medical necessity coverage criteria for a ventilator and at least one of the four additional functions (namely, oxygen concentrator, cough stimulator, suction pump, and nebulizer). HCPCS code E0467 is used to describe multi-function ventilators. **Starting in April 2020, the Centers for Medicare & Medicaid Services (CMS) permanently suspended claims editing for multi-function ventilators when there are claims for separate devices in history that have not met their reasonable useful lifetime.**

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)20012.

Extension of Payment for Section 3712 of the CARES Act

MLN Matters Number: MM11784
Related CR Release Date: May 8, 2020
Related CR Transmittal Number: R10116OTN
Related Change Request (CR) Number: 11784
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

CR 11784 informs you of the implementation of the new April 2020 DMEPOS fee schedule amounts based on changes mandated by Section 3712 (b) of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Make sure your staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11784.

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

MLN Matters Number: MM11778
Related CR Release Date: May 15, 2020
Related CR Transmittal Number: R10135CP
Related Change Request (CR) Number: 11778
Effective Date: June 16, 2020
Implementation Date: June 16, 2020

CR 11778 informs you that Medicare will remove Section 20 (and all of its subsections) of the Medicare Claims Processing Manual (Identification of Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico). The key impact is that modifier CS is no longer to be used to denote services related to the 2010 oil spill.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11778.

Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) - Revised

MLN Matters Number: SE20011 Revised
Article Release Date: April 10, 2020

Note: CMS revised this article on April 10, 2020, to:

- Link to all the blanket waivers related to COVID-19
- Provide place of service coding guidance for telehealth claims
- Link to the Telehealth Video for COVID-19
- Add information on the waiver of coinsurance and deductibles for certain testing and related services
- Add information on the expanded use of ambulance origin/destination modifiers
- Provide new specimen collection codes for clinical diagnostic laboratories billing
- Add guidance regarding delivering notices to beneficiaries.

All other information is the same.

The Secretary of the Department of Health & Human Services declared a public health emergency (PHE) in the entire United States on January 31, 2020. On March 13, 2020 Secretary Azar authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to March 1, 2020.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)20011.

Medicare Pharmacies and Other Suppliers May Temporarily Enroll as Independent Clinical Diagnostic Laboratories to Help Address COVID-19 Testing

MLN Matters Number: SE20017
Article Release Date: May 8, 2020

SE20017 informs that Pharmacies and other suppliers currently enrolled in Medicare may also enroll temporarily as independent clinical diagnostic laboratories during the COVID-19 public health emergency via the provider enrollment hotline. This will provide additional laboratory resources to meet the urgent need to increase COVID-19 testing capability.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)200017.

Your Source for All Noridian COVID-19 Information

Are you feeling overwhelmed with the amount of information you are receiving on COVID-19? We hope to help by providing all COVID-19 related information for Part A, Part B, or DME on a single web page for each payer.

When you go to the main A, B, or DME Noridian home page for your jurisdiction, you will see the COVID-19 Banner in bright orange. In this box you will see the following sentence.

Visit Noridian's COVID-19 page for information and guidance related to COVID-19.

Select the COVID-19 link to find all information on COVID-19 from CMS and Noridian relating to either Part A, Part B or DME. This is the page we will update on an ongoing basis with new information or changes.

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

MLN Matters Number: MM11701
Related CR Release Date: March 20, 2020
Related CR Transmittal Number: R10003CP
Related Change Request (CR) Number: 11701
Effective Date: April 1, 2020
Implementation Date: April 6, 2020

CR 11701 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) supplies MACs with 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 that are available in Chapter 4, Section 50 of the Medicare Claims Processing Manual. Make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11701.

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

MLN Matters Number: MM11745
Related CR Release Date: March 27, 2020
Related CR Transmittal Number: R10017CP
Related Change Request (CR) Number: 11745
Effective Date: July 1, 2020
Implementation Date: July 6, 2020

CR 11745 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) supplies MACs with 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 that are available in Chapter 4, Section 50 of the Medicare Claims Processing Manual. Make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11745.

DMEPOS Fee Schedule - April 2020 Quarterly Update

MLN Matters Number: MM11702
Related CR Release Date: March 20, 2020
Related CR Transmittal Number: R10004CP
Related Change Request (CR) Number: 11702
Effective Date: April 1, 2020
Implementation Date: April 6, 2020

CR 11702 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. The update process for the DMEPOS fee schedule is available in the Medicare Claims Processing Manual, Chapter 23,

Section 60 at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf. Make sure your billing staff is aware of this update.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11702.

LCD and Policy Article Revisions Summary for March 5, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are: Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, Spinal Orthoses: TLSO and LSO, Surgical Dressings, and Therapeutic Shoes for Persons with Diabetes. Please review the entire LCDs and related PAs for complete information.

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea

LCD

Revision Effective Date: 01/01/2020

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: “face-to-face” to “in-person” where applicable
Revised: "practitioner" to "treating practitioner"
Revised: Order information as a result of Final Rule 1713

REFILL REQUIREMENTS:
Revised: Format of HCPCS code references, from code spans to individually-listed HCPCS
Revised: “ordering physicians” to “treating practitioners”

CODING INFORMATION:
Removed: Field titled “Bill Type”
Removed: Field titled “Revenue Codes”
Removed: Field titled “ICD-10 Codes that Support Medical Necessity”
Removed: Field titled “ICD-10 Codes that DO NOT Support Medical Necessity”
Removed: Field titled “Additional ICD-10 Information”

GENERAL DOCUMENTATION REQUIREMENTS:
Revised: Prescriptions (orders) to SWO

03/05/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713, HCPCS code changes, and non-substantive corrections (listing individual HCPCS codes instead of a HCPCS code-span).

PA

Revision Effective Date: 01/01/2020

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g) section

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: "in-person" to initial evaluation
Revised: "practitioner" to "treating practitioner"
Removed: Dispensing order and WOPD related information

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Section header “ICD-10 Codes that are Covered” updated to “ICD-10 Codes that Support Medical Necessity”

ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:
Revised: Section header “ICD-10 Codes that are Not Covered” updated to “ICD-10 Codes that DO NOT Support Medical Necessity”

03/05/2020: 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.

Spinal Orthoses: TLSO and LSO

LCD

Revision Effective Date: 01/01/2020

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS
Revised: Order information as a result of Final Rule 1713

CODING INFORMATION:
Removed: Field titled "Bill Type"
Removed: Field titled "Revenue Codes"
Removed: Field titled "ICD-10 Codes that Support Medical Necessity"
Removed: Field titled "ICD-10 Codes that DO NOT Support Medical Necessity"
Removed: Field titled "Additional ICD-10 Information"

DOCUMENTATION REQUIREMENTS:
Revised: "physician's" to "treating practitioner's"

GENERAL DOCUMENTATION REQUIREMENTS:
Revised: Prescriptions (orders) to SWO

03/05/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713, HCPCS code changes, and non-substantive corrections (listing individual HCPCS codes instead of a HCPCS code-span).

PA

Revision Effective Date: 01/01/2020

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: "ordering physician" to "treating practitioner"
Revised: "prescribing practitioner" to "treating practitioner"

CODING GUIDELINES:
Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS
Revised: HCPCS codes referenced for body jacket type orthoses, to include L0651
Revised: HCPCS codes referenced for billing of prefabricated orthoses, to include L0640, L0641, L0642, L0643, L0648, L0649, L0650, and L0651

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity"

ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity"

03/05/2020: 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.

Surgical Dressings

PA

Revision Effective Date: 01/01/2020

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: Initial wound evaluation record specifications
Clarified: Direction on need for weekly evaluations

Added: Statement that the person doing the evaluation may have no financial relation with the supplier
Clarified: Ongoing evaluations as "weekly or monthly"

03/05/2020: 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.

Therapeutic Shoes for Persons with Diabetes

LCD

Revision Effective Date: 01/01/2020

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Revised: Order information as a result of Final Rule 1713

CODING INFORMATION:
Removed: Field titled "Bill Type"
Removed: Field titled "Revenue Codes"
Removed: Field titled "ICD-10 Codes that Support Medical Necessity"
Removed: Field titled "ICD-10 Codes that DO NOT Support Medical Necessity"
Removed: Field titled "Additional ICD-10 Information"

GENERAL DOCUMENTATION REQUIREMENTS:
Revised: "Prescriptions (orders)" to "SWO"

03/05/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713

PA

Revision Effective Date: 01/01/2020

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Order information as a result of Final Rule 1713

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

CODING GUIDELINES:
Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS
Revised: HCPCS codes referenced for inserts and modifications, to include A5514

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity"

ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity"

03/05/2020: 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.

LCD and Policy Article Revisions Summary for March 12, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Lower Limb Prostheses, Power Mobility Devices, and Wheelchair Seating. Please review the entire LCDs and related PAs for complete information.

Lower Limb Prostheses

LCD

Revision Effective Date: 01/01/2020

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Revised: Format of HCPCS code references, from code ‘spans' to individually-listed HCPCS
Revised: "physician" to "practitioner"
Revised: "physician's" to "treating practitioner's"
Revised: Order information as a result of Final Rule 1713

CODING INFORMATION:
Removed: Field titled "Bill Type"
Removed: Field titled "Revenue Codes"
Removed: Field titled "ICD-10 Codes that Support Medical Necessity"
Removed: Field titled "ICD-10 Codes that DO NOT Support Medical Necessity"
Removed: Field titled "Additional ICD-10 Information"

DOCUMENTATION REQUIREMENTS:
Revised: "physician's" to "treating practitioner's"

GENERAL DOCUMENTATION REQUIREMENTS:
Revised: Prescriptions (orders) to SWO

03/12/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713, HCPCS code changes, and non-substantive corrections (listing individual HCPCS codes instead of a HCPCS code-span).

PA

Revision Effective Date: 01/01/2020

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Format of HCPCS codes referenced, from code ‘spans' to individually-listed HCPCS
Revised: "physician's" to "treating practitioner's"
Revised: "physician" to "practitioner"

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

POLICY SPECIFIC DOCUMENTATION REQUIRMENTS:
Revised: Format of HCPCS code references, from code ‘spans' to individually-listed HCPCS
Revised: "ordering physician" to "treating practitioner"
Revised: "physician's" to "treating practitioner's"

CODING GUIDELINES:
Revised: Section to include sub-headers for organization of coding guidelines and related information
Added: Information related to prosthetic systems, sockets, and Infinite Socket information
Revised: Format of HCPCS code references, from code ‘spans' to individually-listed HCPCS
Added: Coding guidelines and related information for Knees, Ankles, Feet, and Microprocessor Ankle Foot Systems

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity"

ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity"

03/12/2020: 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.

Power Mobility Devices

LCD

Revision Effective Date: 01/01/2020

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: Definition of "treating practitioner"
Revised: Format of HCPCS code references, from code ‘spans' to individually-listed HCPCS

MISCELLANEOUS:
Revised: Format of HCPCS code references, from code ‘spans' to individually-listed HCPCS
Revised: Reference to weight range capacity for heavy duty PWCs and POVs from "400" to "450"

CODING INFORMATION:
Removed: Field titled "Bill Type"
Removed: Field titled "Revenue Codes"
Removed: Field titled "ICD-10 Codes that Support Medical Necessity"
Removed: Field titled "ICD-10 Codes that DO NOT Support Medical Necessity"
Removed: Field titled "Additional ICD-10 Information"

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: Section information to include SWO for options/accessories, WOPD for PMD base item, and face-to-face encounter related information
Added: Statement indicating that if the supplier does not receive SWO (for the PMD base) prior to delivery, the claim will deny as not reasonable and necessary

03/12/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713, HCPCS code changes, and non-substantive corrections (listing individual HCPCS codes instead of a HCPCS code-span).

PA

Revision Effective Date: 01/01/2020

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Order and face-to-face encounter denial-related information
Revised: Section information to include that if the treating practitioner does not conduct the face-to-face encounter and write the SWO for the PMD base, the claim will deny as statutorily non-covered

FACE-TO-FACE ENCOUNTER:
Revised: Section information related to face-to-face encounters, LCMP evaluation, and 6-month timeframe
Removed: Custom motorized/power wheelchair base (K0013) information

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

MISCELLANEOUS:
Added: Custom motorized/power wheelchair base (K0013) information, previously located in FACE-TO-FACE ENCOUNTER section

CODE-SPECIFIC REQUIREMENTS:
Revised: Format of HCPCS code references, from code ‘spans' to individually-listed HCPCS

03/12/2020: 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.

Wheelchair Seating

LCD

Revision Effective Date: 01/01/2020

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS
Removed: Statement to refer to ICD-10 Codes that are Covered section in the LCD-related PA
Added: Statement to refer to the ICD-10 code list in the LCD-related Policy Article
Revised: Order information as a result of Final Rule 1713

CODING INFORMATION:
Removed: Field titled "Bill Type"
Removed: Field titled "Revenue Codes"
Removed: Field titled "ICD-10 Codes that Support Medical Necessity"
Removed: Field titled "ICD-10 Codes that DO NOT Support Medical Necessity"
Removed: Field titled "Additional ICD-10 Information"

DOCUMENTATION REQUIREMENTS:
Revised: "physician's" to "treating practitioner's"

GENERAL DOCUMENTATION REQUIREMENTS:
Revised: Prescriptions (orders) to SWO

03/12/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713, HCPCS code changes, and non-substantive corrections (listing individual HCPCS codes instead of a HCPCS code-span).

PA

Revision Effective Date: 01/01/2020

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g):
Removed: Section due to Final Rule 1713

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: "ICD-10 Codes that are Covered" to "ICD-10 code list"
Revised: Information related to GY modifier use, as a result of Final Rule 1713

CODING GUIDELINES:
Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity"
Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS, in Groups 2 and 3 Paragraphs
ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity"

03/12/2020: 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.

LCD and Policy Article Revisions Summary for March 19, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determination (LCD) and Policy Article (PA) that have been revised and posted. The policy included is Wheelchair Options/Accessories. Please review the entire LCD and related PA for complete information.

Wheelchair Options/Accessories

LCD

Revision Effective Date: 01/01/2020

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Revised: Format of HCPCS code references, from code ‘spans’ to individually-listed HCPCS
Revised: "physician" to "practitioner"
Revised: Order information as a result of Final Rule 1713

CODING INFORMATION:
Removed: Field titled “Bill Type”
Removed: Field titled “Revenue Codes”
Removed: Field titled “ICD-10 Codes that Support Medical Necessity”
Removed: Field titled “ICD-10 Codes that DO NOT Support Medical Necessity”
Removed: Field titled “Additional ICD-10 Information”

DOCUMENTATION REQUIREMENTS:
Revised: “physician’s” to “treating practitioner’s”

GENERAL DOCUMENTATION REQUIREMENTS:
Revised: Prescriptions (orders) to SWO

03/19/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713, HCPCS code changes, and non-substantive corrections (listing individual HCPCS codes instead of a HCPCS code-span).

PA

Revision Effective Date: 01/01/2020

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g):
Removed: Section due to Final Rule 1713

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: Information related to GY modifier use, as a result of Final Rule 1713

CODING GUIDELINES:
Revised: Format of HCPCS code references, from code 'spans' to individually-listed HCPCS
Revised: Column II of table, to include E2398 for manual wheelchair bases and power wheelchair bases

03/19/2020: 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.

LCD and Policy Article Revisions Summary for April 2, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Nebulizers and Standard Documentation Requirements for All Claims Submitted to DME MACs. Please review the entire LCD and related PAs for complete information.

Nebulizers

LCD

Revision Effective Date: 05/17/2020

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Statement regarding base and related accessories and supplies (BPM Ch. 15, Section 110.3)
Clarified: “considered for coverage” to drug and equipment criteria
Added: Revefenacin to inhalation solutions for the management of obstructive pulmonary disease - For Dates of Service on or after 11/9/2018 (FDA Approval Date)
Revised: “alpha” to “alfa” in relation to HCPCS code J7639
Removed: Statement to refer to ICD-10 Codes that are Covered section in the LCD-related PA
Added: Statement to refer to ICD-10 codes in the LCD-related Policy Article
Revised: “alpha” to “alfa” in table with maximum milligrams/month
Added: Revefenacin to table with maximum milligrams/month
Added: Information regarding concurrent use of long-acting and short-acting muscarinic antagonists
Revised: Format of HCPCS code references, from code ‘spans’ to individually-listed HCPCS codes
Revised: "physician" to "practitioner"
Revised: Order information as a result of Final Rule 1713

REFILL REQUIREMENTS:

Revised: "ordering physicians" to "treating practitioners"

SUMMARY OF EVIDENCE:
Added: Information related to revefenacin

ANALYSIS OF EVIDENCE:
Added: Information related to revefenacin

HCPCS CODES:
Added: J7677 to Group 3 Codes in the HCPCS code table

CODING INFORMATION:
Removed: Field titled “Bill Type”
Removed: Field titled “Revenue Codes”
Removed: Field titled “ICD-10 Codes that Support Medical Necessity”
Removed: Field titled “ICD-10 Codes that DO NOT Support Medical Necessity”
Removed: Field titled “Additional ICD-10 Information”

GENERAL DOCUMENTATION REQUIREMENTS:
Revised: Prescriptions (orders) to SWO

BIBLIOGRAPHY:
Added: Section related to revefenacin

RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments (A58035)

PA

Revision Effective Date: 05/17/2020

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: STATUTORY PRESCRIPTION (ORDER) REQUIRMENTS section
Removed: REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g) section
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

CODING GUIDELINES:
Revised: “alpha” to “alfa” in relation to HCPCS code J7639
Added: Coding guidelines for J7677

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Section header “ICD-10 Codes that are Covered” updated to “ICD-10 Codes that Support Medical Necessity”
Added: HCPCS code J7677 to Group 8 Paragraph

Revised: ICD-10 code descriptor for J44.0, per ICD-10 code update

ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:
Revised: Section header “ICD-10 Codes that are Not Covered” updated to “ICD-10 Codes that DO NOT Support Medical Necessity”

04/02/2020: 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.

Standard Documentation Requirements for All Claims Submitted to DME MACs

PA

Revision Effective Date: 04/06/2020

REFILL DOCUMENTATION:
Added: "REQUIREMENTS" to title

PROOF OF DELIVERY (POD):
Added: Prohibition for billing prior to discharge date

04/02/2020: 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.

With the update(s) listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
        i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        ii. There are direct links to all LCDs under the ‘LCD ID number and Effective Date’ column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

LCD and Policy Article Revisions Summary for April 16, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determination (LCD) and Policy Article (PA) that have been revised and posted. The policy included is External Infusion Pumps. Please review the entire LCD and related PA for complete information.

External Infusion Pumps

LCD

Revision Effective Date: 05/31/2020

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Statement regarding base and related accessories and supplies (BPM Ch. 15, Section 110.3)
Revised: “physician” to “practitioner”
Added: Xembify® to coverage criteria V(H)
Added: Statement regarding covered pumps for Xembify®
Revised: “physicians” to “practitioners”

GENERAL:
Revised: Order information as a result of Final Rule 1713
REFILL REQUIREMENTS:
Revised: “ordering physicians” to “treating practitioners”

SUMMARY OF EVIDENCE:
Added: Information related to Xembify®

ANALYSIS OF EVIDENCE:
Added: Information related to Xembify®

CODING INFORMATION:
Removed: Field titled “Bill Type”
Removed: Field titled “Revenue Codes”
Removed: Field titled “ICD-10 Codes that Support Medical Necessity”
Removed: Field titled “ICD-10 Codes that DO NOT Support Medical Necessity”
Removed: Field titled “Additional ICD-10 Information”

DOCUMENTATION REQUIREMENTS:
Revised: “physician's” to “treating practitioner's”

GENERAL DOCUMENTATION REQUIREMENTS:
Revised: Prescriptions (orders) to SWO

BIBLIOGRAPHY:
Added: Section related to Xembify®

RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments document

PA

Revision Effective Date: 05/31/2020

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: “physician’s” to “practitioner’s”
Removed: REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g) section

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

DME INFORMATION FORM (DIF):
Revised: “physician” to “practitioner”

MODIFIERS:
Added: J7799 (Xembify®) to the JB modifier requirements

CODING GUIDELINES:
Revised: 'detailed order' to 'standard written order'
Added: UOS billing instruction for J7799 (Xembify®)

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: J7799 (Xembify®) to the Group 3 paragraph

04/16/2020: 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.

With the update(s) listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
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        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

Policy Article Revisions Summary for April 30, 2020

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

PA

Revision Effective Date: 04/30/2020

CODING GUIDELINES:
Removed: Statement indicating calorically dense formulas that include characteristics of other HCPCS codes, will be coded based on the calorically dense characteristic

04/30/2020: 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.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
        i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

New Medicare Beneficiary Identifier (MBI) Get It, Use It - Revised

MLN Matters Number: SE18006 Revised
Article Release Date: March 19, 2020

Note: CMS revised the article on March 19, 2020, to clarify that you need the beneficiary's first name, last name, date of birth, and SSN to use MBI look-up tool. All other information remains the same.

Use MBIs for all Medicare transactions. The Centers for Medicare & Medicaid Services (CMS) replaced the Social Security Number (SSN)-based Health Insurance Claim Numbers (HICNs) with the MBI and mailed new Medicare cards to all Medicare beneficiaries. The cards with MBIs offer better identity protection.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)18006.

MLN Connects Special Edition - March 4, 2020

CMS Announces Actions to Address Spread of Coronavirus

CMS calls on all health care providers to activate infection control practices and issues guidance to inspectors as they inspect facilities affected by Coronavirus

On March 4, the Centers for Medicare & Medicaid Services (CMS) announced several actions aimed at limiting the spread of the Novel Coronavirus 2019 (COVID-19). Specifically, CMS is issuing a call to action to health care providers across the country to ensure they are implementing their infection control procedures, which they are required to maintain at all times. Additionally, CMS is announcing that, effective immediately and, until further notice, State Survey Agencies and Accrediting Organizations will focus their facility inspections exclusively on issues related to infection control and other serious health and safety threats, like allegations of abuse - beginning with nursing homes and hospitals. Critically, this shift in approach, first announced yesterday by Vice President Pence, will allow inspectors to focus their energies on addressing the spread of COVID-19.

As the agency responsible for Medicare and Medicaid, CMS requires facilities to maintain infection control and prevention policies as a condition for participation in the programs. CMS is also issuing three memoranda to State Survey Agencies, State Survey Agency directors and Accrediting Organizations - to inspect thousands of Medicare-participating health care providers across the country, including nursing homes and hospitals.

"Today's actions, taken together, represent a call to action across the health care system," said CMS Administrator Seema Verma. "All health care providers must immediately review their procedures to ensure compliance with CMS' infection control requirements, as well as the guidelines from the Centers for Disease Control and Prevention (CDC). We sincerely appreciate the proactive efforts of the nursing home and hospital associations that have already galvanized to provide up-to-the-minute information to their members. We must continue working together to keep American patients and residents safe and healthy and prevent the spread of COVID-19."

The first memorandum provides important detail with respect to the temporary focus of surveys on infection control and other emergent issues. Importantly, it notes that, in addition to the focused inspections, statutorily-required inspections will also continue in the 15,000 nursing homes across the country using the approximately 8,200 state survey agency surveyors. Surveys will be conducted according to the following regime:

- All immediate jeopardy complaints (a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death or harm) and allegations of abuse and neglect;
- Complaints alleging infection control concerns, including facilities with potential COVID-19 or other respiratory illnesses;
- Statutorily required recertification surveys (Nursing Home, Home Health, Hospice, and ICF/IID facilities);
- Any re-visits necessary to resolve current enforcement actions;
- Initial certifications;
- Surveys of facilities/hospitals that have a history of infection control deficiencies at the immediate jeopardy level in the last three years;
- Surveys of facilities/hospitals/dialysis centers that have a history of infection control deficiencies at lower levels than immediate jeopardy.

The memorandum also includes protocols for the inspection process in situations in which COVID-19 is identified or suspected. These protocols include working closely with CMS regional offices, coordinating with CDC, and other relevant agencies at all levels of government. The agency is also providing key guidance related to inspectors' usage of adequate personal protective equipment.

The other two memoranda provide critical answers to common questions that nursing homes and hospitals may have with respect to addressing cases of COVID-19. For example, the memoranda discuss concerns like screening staff and visitors with questions about recent travel to countries with known cases and the severity of infection that would warrant hospitalization instead of self-isolation. They detail the process for transferring patients between nursing homes and hospitals in cases for which COVID-19 is suspected or diagnosed. They also describe the circumstances under which providers should take precautionary measures (like isolation and mask wearing) for patients and residents diagnosed with COVID-19, or showing signs and symptoms of COVID-19.

Finally, the agency is announcing that it has deployed an infection prevention specialist to CDC's Atlanta headquarters to assist with real-time in guidance development.

These actions from CMS are focused on protecting American patients and residents by ensuring health care facilities have up-to-date information to adequately respond to COVID-19 concerns while also making it clear to providers that as always, CMS will hold them accountable for effective infection control standards. The agency is also supplying inspectors with necessary and timely information to safely and accurately inspect facilities.

To view each memo, please visit:

- Suspension of Survey Activities
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes

MLN Connects - March 5, 2020

Ambulance Fee Schedule, Transports & Data Collection

MLN Connects® for Thursday, March 5, 2020
View this edition as a PDF

News

- DMEPOS Suppliers: HCPCS Codes Affected by Further Consolidated Appropriations Act
- Medicare Promoting Interoperability Program: CAH Reconsideration Forms due March 6
- Medicare Promoting Interoperability Program: Submit Proposals for New Measures by July 1
- PEPPERs for Short-term Acute Care Hospitals
- 2018 Geographic Variation Public Use File
- Help Your Patients Make Informed Food Choices

Compliance

- Ambulance Fee Schedule and Medicare Transports

Claims, Pricers & Codes

- Average Sales Price Files: April 2020

Events

- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call - March 12
- Open Payments: Your Role in Health Care Transparency Call - March 19
- Anesthesia Modifiers: Comparative Billing Report Webinar - March 19
- Ground Ambulance Organizations: Data Collection for Medicare Providers Call - April 2
- LTCH and IRF Quality Reporting Programs: SPADEs In-Depth Training Event - June 9-10

MLN Matters® Articles

- Standard Elements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2020
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - July 2020 Update

Publications

- Administrative Simplification: Claim Status Basics
- Hospice Quality Reporting Program: Timeliness Compliance Threshold for HIS Submissions
- Guide to Reducing Chronic Kidney Disease Disparities in the Primary Care Setting

Multimedia

- Ambulance Services Call: Audio Recording and Transcript

MLN Connects Special Edition - March 6, 2020

CMS Develops Additional Code for Coronavirus Lab Tests

Agency Issues Fact Sheets Detailing Coverage under Programs

On March 6, CMS took additional actions to ensure America's patients, healthcare facilities and clinical laboratories are prepared to respond to the 2019-Novel Coronavirus (COVID-19).

CMS has developed a second Healthcare Common Procedure Coding System (HCPCS) code that can be used by laboratories to bill for certain COVID-19 diagnostic tests to help increase testing and track new cases. In addition, CMS released new fact sheets that explain Medicare, Medicaid, Children's Health Insurance Program, and Individual and Small Group Market Private Insurance coverage for services to help patients prepare as well.

"CMS continues to leverage every tool at our disposal in responding to COVID-19," said CMS Administrator Seema Verma. "Our new code will help encourage doctors and laboratories to use these essential tests for patients who need them. At the same time, we are providing critical information to our 130 million beneficiaries, many of whom are understandably wondering what will be covered when it comes to this virus. CMS will continue to devote every available resource to this effort, as we cooperate with other government agencies to keep the American people safe."

HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. Last month, CMS developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. The second HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). On February 29, 2020, the Food and Drug Administration (FDA) issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics. This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects that having specific codes for these tests will encourage testing and improve tracking.

The Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. Laboratories may seek guidance from their MAC on payment for these tests prior to billing for them. As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

To ensure the public has clear information on coverage and benefits under CMS programs, the agency also released three fact sheets that cover diagnostic laboratory tests, immunizations and vaccines, telemedicine, drugs, and cost-sharing policies

Medicare Fact Sheet Highlights: In addition to the diagnostic tests described above, Medicare covers all medically necessary hospitalizations, as well as brief "virtual check-ins," which allows patients and their doctors to connect by phone or video chat.

Medicaid and Children's Health Insurance Program (CHIP) Fact Sheet Highlights: Testing and diagnostic services are commonly covered services, and laboratory and x-ray services are a mandatory benefit covered and reimbursed in all states. States are required to provide both inpatient and outpatient hospital services to beneficiaries. All states provide coverage of hospital care for children and pregnant women enrolled in CHIP. Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage: Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of with Coronavirus (COVID-19). This includes plans

purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

Summary of CMS Public Health Action on COVID-19 to date:

On March 4, 2020, CMS issued a call to action to healthcare providers nationwide to ensure they are implementing longstanding infection control procedures and issued important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare facilities to focus exclusively on issues related to infection control and other serious health and safety threats. For more information on CMS actions to prepare for and respond to COVID-19, visit: CMS Announces Actions to Address Spread of Coronavirus.

On February 13, 2020, CMS issued a new HCPCS code for healthcare providers and laboratories to test patients for COVID-19 using the CDC-developed test. For more information about this code: Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test.

On February 6, 2020, CMS issued a memo to help the nation's healthcare facilities take critical steps to prepare for COVID19.

On February 6, 2020, CMS also gave CLIA-certified laboratories information about how they can test for SARS-CoV-2. Read more: Suspension of Survey Activities memorandum

For the updated information on the range of CMS activities to address COVID-19, visit the Current Emergencies webpage.

MLN Connects Special Edition - March 9, 2020

COVID-19 Response: CMS Issues FAQs to Assist Medicare Providers

On March 6, CMS issued frequently asked questions and answers (FAQs) for health care providers regarding Medicare payment for laboratory tests and other services related to the 2019-Novel Coronavirus (COVID-19). The agency is receiving questions from providers and created this document to be transparent and share answers to some of the most common questions.

Included in the FAQs is:

- Guidance on how to bill and receive payment for testing patients at risk of COVID-19.
- Details of Medicare's payment policies for laboratory and diagnostic services, drugs, and vaccines under Medicare Part B, ambulance services, and other medical services delivered by physicians, hospitals, and facilities accepting government resources.
- Information on billing for telehealth or in-home provider services. Since 2019, the Trump Administration has expanded flexibilities for CMS to pay providers for virtual check-ins and other digital communications with patients, which will make it easier for sick patients to stay home and lower the risk of spreading the infection.

This FAQ, and earlier CMS actions in response to the COVID-19 virus are part of the ongoing White House Task Force efforts. To keep up with the important work CMS is doing in response to COVID-19, visit the Current Emergencies website.

Below is an updated list of CMS' actions to date:

- March 5: Issued a second Healthcare Common Procedure Coding System (HCPCS) code for certain COVID-19 laboratory tests, in addition to three fact sheets about coverage and benefits for medical services related to COVID-19 for CMS programs
- March 4: Issued a call to action to health care providers nationwide and offered important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare
- February 13: Issued a new HCPCS code for providers and laboratories to test patients for COVID-19
- February 6: Gave CLIA-certified laboratories information about how they can test for SARS-CoV-2
- February 6: Issued a memo to help the nation's health care facilities take critical steps to prepare for COVID-19

MLN Connects - March 12, 2020

2019 Novel Coronavirus Guidance

MLN Connects® for Thursday, March 12, 2020
View this edition as a PDF

News

- CMS Sends More Detailed Guidance to Providers about COVID-19
- HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data
- Quality Payment Program: MIPS 2019 Data Submission Deadline March 31
- Hospital Quality Reporting: Comment on Draft QRDA I Implementation Guide by April 1
- Inclusion of Lower Limb Prosthetics in DMEPOS Prior Authorization
- Clean Hands Count: Prevent and Control Infections
- March is National Colorectal Cancer Awareness Month

Compliance

- Incorrect Billing of HCPCS L8679 - Implantable Neurostimulator, Pulse Generator, Any Type

Events

- Open Payments: Your Role in Health Care Transparency Call - March 19
- Medicare Promoting Interoperability Program Call for Measures Webinar - March 19
- Ground Ambulance Organizations: Data Collection for Medicare Providers Call - April 2
- Interoperability and Patient Access Final Rule Call - April 7
- LTCH and IRF Quality Reporting Programs: SPADEs Webinar - April 14

MLN Matters® Articles

- NCD 20.4 Implantable Cardiac Defibrillators (ICDs)
- Section 1876 and 1833 Cost Plan Enrollee Access to Care through Original Medicare
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1
- Proper Use of Modifier 59 - Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update - Revised

Publications

- Evacuating and Receiving Patients in the Midst of a Wildfire
- Administrative Simplification: Eligibility and Benefits Transaction Basics

Multimedia

- Dementia Care Call: Audio Recording and Transcript

MLN Connects Special Edition - March 13, 2020

COVID-19: Test Pricing; Diagnostic Lab Tests, Pricing & Codes; and EHB Coverage

On March 12, CMS posted a fact sheet with information relating to the pricing of both the Centers for Disease Control and Prevention (CDC) and non-CDC tests.

Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters® Article

A new MLN Matters Article MM 11681 on Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment is available. Learn about Advanced Diagnostic Laboratory Tests, pricing, and new codes. On page 3, we reference new COVID-19 codes.

Essential Health Benefits (EHB) Coverage

On March 12, CMS issued Frequently Asked Questions (FAQs) about EHB to ensure individuals, issuers, and states have clear information on coverage benefits for COVID-19. This action is part of the broader, ongoing effort by the White House Coronavirus Task Force to ensure that all Americans - particularly those at high-risk of complications from the COVID-19 virus - have access to the health benefits that can help keep them healthy while helping to contain the spread of this disease.

These FAQs, and earlier CMS actions in response to the COVID-19 virus, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19; visit the CDC's Coronavirus Disease 2019 webpage.

For information specific to CMS, please visit the Current Emergencies website.

MLN Connects Special Edition - March 16, 2020 - COVID-19: FFS Response and Nursing Home Visitor Guidance

Medicare FFS Response to COVID-19

The HHS Secretary declared a public health emergency, which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article SE20011 on Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus is available. Learn about blanket waivers issued by CMS. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency.

See the press release outlining our announcement.

COVID-19 Nursing Home Visitor Guidance

On March 13, as part of the broader Trump Administration announcement, CMS announced critical new measures designed to keep America's nursing home residents safe from the 2019 Novel Coronavirus (COVID-19). The measures take the form of a memorandum and is based on the newest recommendations from the Centers for Disease Control and Prevention (CDC). It directs nursing homes to significantly restrict visitors and nonessential personnel, as well as restrict communal activities inside nursing homes. The new measures are CMS's latest action to protect America's seniors, who are at highest risk for complications from COVID-19. While visitor restrictions may be difficult for residents and families, it is an important temporary measure for their protection.

For More Information:

- Press Release
- Memo Nursing Home Guidance QSO-20-14 -NH

This guidance, and earlier CMS actions in response to the COVID-19 virus, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit the coronavirus.gov webpage.

For information specific to CMS, visit the Current Emergencies website.

MLN Connects Special Edition - March 17, 2020 - President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak

CMS Outlines New Flexibilities Available to People with Medicare

The Trump Administration today announced expanded Medicare telehealth coverage that will enable beneficiaries to receive a wider range of healthcare services from their doctors without having to travel to a healthcare facility. Beginning on March 6, 2020, Medicare-administered by the Centers for Medicare & Medicaid Services (CMS)-will temporarily pay clinicians to provide telehealth services for beneficiaries residing across the entire country.

"The Trump Administration is taking swift and bold action to give patients greater access to care through telehealth during the COVID-19 outbreak," said Administrator Seema Verma. "These changes allow seniors to communicate with their doctors

without having to travel to a healthcare facility so that they can limit risk of exposure and spread of this virus. Clinicians on the frontlines will now have greater flexibility to safely treat our beneficiaries."

On March 13, 2020, President Trump announced an emergency declaration under the Stafford Act and the National Emergencies Act. Consistent with President Trump's emergency declaration, CMS is expanding Medicare's telehealth benefits under the 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act. This guidance and other recent actions by CMS provide regulatory flexibility to ensure that all Americans-particularly high-risk individuals-are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to contain the spread of coronavirus disease 2019 (COVID-19).

Prior to this announcement, Medicare was only allowed to pay clinicians for telehealth services such as routine visits in certain circumstances. For example, the beneficiary receiving the services must live in a rural area and travel to a local medical facility to get telehealth services from a doctor in a remote location. In addition, the beneficiary would generally not be allowed to receive telehealth services in their home.

The Trump Administration previously expanded telehealth benefits. Over the last two years, Medicare expanded the ability for clinicians to have brief check-ins with their patients through phone, video chat and online patient portals, referred to as "virtual check-ins". These services are already available to beneficiaries and their physicians, providing a great deal of flexibility, and an easy way for patients who are concerned about illness to remain in their home avoiding exposure to others.

A range of healthcare providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to Medicare beneficiaries. Beneficiaries will be able to receive telehealth services in any healthcare facility including a physician's office, hospital, nursing home or rural health clinic, as well as from their homes.

Medicare beneficiaries will be able to receive various services through telehealth including common office visits, mental health counseling, and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home, without having to go to a doctor's office or hospital which puts themselves or others at risk. This change broadens telehealth flexibility without regard to the diagnosis of the beneficiary, because at this critical point it is important to ensure beneficiaries are following guidance from the CDC including practicing social distancing to reduce the risk of COVID-19 transmission. This change will help prevent vulnerable beneficiaries from unnecessarily entering a healthcare facility when their needs can be met remotely.

President Trump's announcement comes at a critical time as these flexibilities will help healthcare institutions across the nation offer some medical services to patients remotely, so that healthcare facilities like emergency departments and doctor's offices are available to deal with the most urgent cases and reduce the risk of additional infections. For example, a Medicare beneficiary can visit with a doctor about their diabetes management or refilling a prescription using telehealth without having to travel to the doctor's office. As a result, the doctor's office is available to treat more people who need to be seen in-person and it mitigates the spread of the virus.

As part of this announcement, patients will now be able to access their doctors using a wider range of communication tools including telephones that have audio and video capabilities, making it easier for beneficiaries and doctors to connect.

Clinicians can bill immediately for dates of service starting March 6, 2020. Telehealth services are paid under the Physician Fee Schedule at the same amount as in-person services. Medicare coinsurance and deductible still apply for these services. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Medicaid already provides a great deal of flexibility to states that wish to use telehealth services in their programs. States can cover telehealth using various methods of communication such as telephonic, video technology commonly available on smart phones and other devices. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.

This guidance follows on President Trump's call for all insurance companies to expand and clarify their policies around telehealth.

To read the Fact Sheet on this announcement visit: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

To read the Frequently Asked Questions on this announcement visit: https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

This guidance, and earlier CMS actions in response to the COVID-19 virus, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19 click here http://www.coronavirus.gov/. For information specific to CMS, please visit the Current Emergencies Website.

MLN Connects - March 19, 2020

Interoperability and Patient Access

MLN Connects® for Thursday, March 19, 2020
View this edition as a PDF

News

- Quality Payment Program: 2020 Facility-Based Status
- Lower Extremity Joint Replacement: Comparative Billing Report in March
- IRF Provider Preview Reports: Review Your Data by April 13
- LTCH Provider Preview Reports: Review Your Data by April 13
- Hospice Provider Preview Reports: Review Your Data by April 13
- IRF Compare Refresh
- LTCH Compare Refresh
- LTCH CARE Data Submission Specifications
- Hospital Quality Reporting: Updated 2020 QRDA I Schematron and Sample File
- Influenza Activity Continues: Are Your Patients Protected?

Compliance

- Provider Minute Video: The Importance of Proper Documentation

Claims, Pricers & Codes

- SNF Claims Incorrectly Cancelled

Events

- Ground Ambulance Organizations: Data Collection for Medicare Providers Call - April 2
- Interoperability and Patient Access Final Rule Call - April 7

MLN Matters® Articles

- Ensure Required Patient Assessment Information for Home Health Claims
- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits
- Medicare FFS Response to the Public Health Emergency on the Coronavirus (COVID-19) - Revised

Publications

- Administrative Simplification: Code Set Basics
- Medicare Parts A & B Appeals Process - Revised
- Clinical Laboratory Fee Schedule - Revised

Multimedia

- Part A Appeals Demonstration Call: Audio Recording and Transcript
- Introduction to IRF Quality Reporting Program Web-Based Training
- Introduction to SNF Quality Reporting Program Web-Based Training

MLN Connects Special Edition - March 20, 2020 - COVID-19: Telehealth and Non-Essential Procedures

COVID-19: TELEHEALTH AND NON-ESSENTIAL PROCEDURES

CMS Releases Telehealth Toolkits for General Practitioners and End-Stage Renal Disease (ESRD) Providers

On March 18, the Centers for Medicare & Medicaid Services (CMS) released two comprehensive toolkits on telehealth that are specific to general practitioners as well as providers treating patients with End-Stage Renal Disease (ESRD).

Under President Trump's leadership to respond to the need to limit the spread of COVID-19, CMS has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. These benefits are part of the broader effort by CMS and the White House Task Force to ensure that all Americans - particularly those at high-risk of complications from the virus that causes the disease COVID-19 are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to contain the community spread of this virus.

Each toolkit contains electronic links to reliable sources of information on telehealth and telemedicine, which will reduce the amount of time providers spend searching for answers and increase their time with patients. Many of these links will help providers learn about the general concept of telehealth, choose telemedicine vendors, initiate a telemedicine program, monitor patients remotely, and develop documentation tools. Additionally, the information contained within each toolkit will also outline temporary virtual services that could be used to treat patients during this specific period of time.

You can find the Telehealth Toolkit for General Practitioners here: https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf

You can find the End-Stage Renal Disease Providers Toolkit here: https://www.cms.gov/files/document/esrd-provider-telehealth-telemedicine-toolkit.pdf

CMS continues to monitor the developing COVID-19 situation and assess options to bring relief to clinicians. To keep up with the important work the Task Force is doing in response to COVID-19 visit the coronavirus.gov webpage. For complete and updated information specific to CMS, please visit the Current Emergencies Website.

Medicare FFS Response to the Public Health Emergency on the Coronavirus (COVID-19) - Revised

The MLN Matters Special Edition Article SE20011 on Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) (PDF) was updated to cover the use of modifiers on telehealth claims and to explain that the DR condition code is not needed on telehealth claims under the waiver.

COVID-19 Elective Surgeries and Non-Essential Procedures Recommendations

On March 18, at the White House Task Force Press Briefing, the Centers for Medicare & Medicaid Services (CMS) announced that all elective surgeries, non-essential medical, surgical, and dental procedures be delayed during the 2019 Novel Coronavirus (COVID-19) outbreak.

You can find a copy of the press release here: https://www.cms.gov/newsroom/press-releases/cms-releases-recommendations-adult-elective-surgeries-non-essential-medical-surgical-and-dental

You can find a copy of the guidance here: https://www.cms.gov/files/document/31820-cms-adult-elective-surgery-and-procedures-recommendations.pdf

These recommendations, and earlier CMS guidance and actions in response to the COVID-19 virus, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit the coronavirus.gov webpage for further information. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

MLN Connects Special Edition - March 23, 2020 - COVID-19: Relief for Quality Reporting Programs and Provider Enrollment

Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

On March 22, CMS announced it is granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs. The action comes as part of the Trump Administration's response to 2019 Novel Coronavirus (COVID-19).

CMS is implementing additional extreme and uncontrollable circumstances policy exceptions and extensions for upcoming measure reporting and data submission deadlines for several CMS programs. For those programs with data submission deadlines in April and May 2020, submission of those data will be optional, based on the facility's choice to report.

CMS recognizes that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions, and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period.

You can find a copy of the press release here: https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting

CMS will continue monitoring the developing COVID-19 situation and assess options to provide additional relief to clinicians, facilities, and their staff so they can focus on caring for patients.

This action, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit the coronavirus.gov webpage. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Webpage on CMS.Gov.

COVID-19 Provider Enrollment Relief FAQs

On March 22, CMS released Frequently Asked Questions on Medicare Provider Enrollment Relief related to COVID-19, including the toll-free hotlines available to provide expedited enrollment and answer questions related to COVID-19 enrollment requirements.

A copy of the FAQs can be found here: https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

These tools, and earlier CMS actions in response to the COVID-19 emergency, are all part of ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, please visit the coronavirus.gov webpage. For a complete and updated list of CMS actions, guidance, and other information in response to COVID-19, please visit the Current Emergencies Website.

MLN Connects - March 26, 2020

COVID-19: New Targeted Plan for Health Care Facility Inspections

MLN Connects® for Thursday, March 26, 2020
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News

- CMS Announces Findings at Kirkland Nursing Home and New Targeted Plan for Health Care Facility Inspections in light of COVID-19
- SNF Quality Reporting Program: MDS 3.0 v1.18.1 Release Delayed
- Home Health Quality Reporting Program: Draft OASIS-E Instrument
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

MLN Matters® Articles

- The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2018 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)
- April 2020 Update of the Ambulatory Surgical Center (ASC) Payment System
- April 2020 Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- April Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule
- New Medicare Beneficiary Identifier (MBI) Get It, Use It - Revised
- 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 - Revised

Multimedia

- Ground Ambulance Data Collection System Call: Audio Recording and Transcript

MLN Connects Special Edition - March 26, 2020 - COVID-19: Enrollment Relief, Open Payments, Beneficiary Notices

2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)

CMS released Frequently Asked Questions on Medicare Provider Enrollment Relief related to COVID-19 including the toll-free hotlines available to Medicare Administrative Contractors (MACs). CMS has established toll-free hotlines at each MAC to allow physicians and non-physician practitioners to initiate temporary Medicare billing privileges. These hotlines provide expedited enrollment and answer questions related to COVID-19 enrollment requirements. FAQ

Frequently Asked Questions (FAQs) on Enforcing Open Payments Deadlines

CMS released an updated comprehensive list of Frequently Asked Questions (FAQs) about the Open Payments program. Tuesday, March 31, 2020 is the Open Payments Program Year 2019 data submission deadline for applicable manufacturers and group purchasing organizations (GPOs) to submit and attest to data for the June 2020 publication of Program Year 2019 data. The deadline cannot be extended past March 31, 2020, therefore, CMS will exercise enforcement discretion for submissions completed after the statutory deadline due to circumstances beyond the reporting entity's control related to the pandemic. FAQ

Beneficiary Notice Delivery Guidance in light of COVID-19

If you are treating a patient with suspected or confirmed COVID-19, CMS encourages the provider community to be diligent and safe while issuing the following beneficiary notices to beneficiaries receiving institutional care:

- Important Message from Medicare (IM)_CMS-10065
- Detailed Notices of Discharge (DND)_CMS-10066
- Notice of Medicare Non-Coverage (NOMNC)_CMS-10123
- Detailed Explanation of Non-Coverage (DENC)_CMS-10124
- Medicare Outpatient Observation Notice (MOON)_CMS-10611
- Advance Beneficiary Notice of Non-Coverage (ABN)_CMS-R-131
- Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN)_CMS-10055
- Hospital Issued Notices of Non-Coverage (HINN)

In light of concerns related to COVID-19, current notice delivery instructions provide flexibilities for delivering notices to beneficiaries in isolation. These procedures include:

- Hard copies of notices may be dropped off with a beneficiary by any hospital worker able to enter a room safely. A contact phone number should be provided for a beneficiary to ask questions about the notice, if the individual delivering the notice is unable to do so. If a hard copy of the notice cannot be dropped off, notices to beneficiaries may also delivered via email, if a beneficiary has access in the isolation room. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice, and when and to where the email was sent.

- Notice delivery may be made via telephone or secure email to beneficiary representatives who are offsite. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where the email was sent.

We encourage the provider community to review all of the specifics of notice delivery, as set forth in Chapter 30 of the Medicare Claims Processing Manual. https://www.cms.gov/media/137111

CMS has taken several recent actions in response to the Coronavirus Disease 2019 (COVID-19), as part of the ongoing White House Task Force efforts. A summary of recent CMS activities can be found here: https://www.cms.gov/newsroom/press-releases/cms-news-alert-march-26-2020

To keep up with the important work the Task Force is doing in response to COVID-19, visit https://www.coronavirus.gov/. For information specific to CMS, please visit the CMS News Room and Current Emergencies Website.

MLN Connects Special Edition - March 30, 2020 - COVID-19: Financial Relief, Nursing Home Telehealth, Quality Reporting, Clinical Laboratories, Hospital Data Sharing

Trump Administration Provides Financial Relief for Medicare Providers

Under the President's leadership, the Centers for Medicare & Medicaid Services (CMS) is announcing an expansion of its accelerated and advance payment program for Medicare participating health care providers and suppliers, to ensure they have the resources needed to combat the 2019 Novel Coronavirus (COVID-19). This program expansion, which includes changes from the recently enacted Coronavirus Aid, Relief, and Economic Security (CARES) Act, is one way that CMS is working to lessen the financial hardships of providers facing extraordinary challenges related to the COVID-19 pandemic and ensures the nation's providers can focus on patient care. There has been significant disruption to the health care industry, with providers being asked to delay non-essential surgeries and procedures, other health care staff unable to work due to childcare demands, and disruption to billing, among the challenges related to the pandemic.

"With our nation's health care providers on the front lines in the fight against COVID-19, dollars and cents shouldn't be adding to their worries," said CMS Administrator Seema Verma. "Unfortunately, the major disruptions to the health care system caused by COVID-19 are a significant financial burden on providers. Today's action will ensure that they have the resources they need to maintain their all-important focus on patient care during the pandemic."

Medicare provides coverage for 37.4 million beneficiaries in its Fee for Service (FFS) program, and made $414.7 billion in direct payments to providers during 2019. This effort is part of the Trump Administration's White House Coronavirus Task Force effort to combat the spread of COVID-19 through a whole-of-America approach, with a focus on strengthening and leveraging public-private relationships.

Accelerated and advance Medicare payments provide emergency funding and address cash flow issues based on historical payments when there is disruption in claims submission and/or claims processing. These expedited payments are typically offered in natural disasters to accelerate cash flow to the impacted health care providers and suppliers. In this situation, CMS is expanding the program for all Medicare providers throughout the country during the public health emergency related to COVID-19. The payments can be requested by hospitals, doctors, durable medical equipment suppliers, and other Medicare Part A and Part B providers and suppliers.

To qualify for accelerated or advance payments, the provider or supplier must:

- Have billed Medicare for claims within 180 days immediately prior to the date of signature on the provider's/ supplier's request form,
- Not be in bankruptcy,
- Not be under active medical review or program integrity investigation, and
- Not have any outstanding delinquent Medicare overpayments.

Medicare will start accepting and processing the Accelerated/Advance Payment Requests immediately. CMS anticipates that the payments will be issued within seven days of the provider's request.

An informational fact sheet on the accelerated/advance payment process and how to submit a request can be found here: https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.

This action, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit https://www.coronavirus.gov/. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit

On March 27, CMS issued an electronic toolkit regarding telehealth and telemedicine for Long Term Care Nursing Home Facilities. Under President Trump's leadership to respond to the need to limit the spread of community COVID-19, CMS has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. This document contains electronic links to reliable sources of information regarding telehealth and telemedicine, including the significant changes made by CMS over the last week in response to the National Health Emergency. Most of the information is directed towards providers who may want to establish a permanent telemedicine program, but there is information here that will help in the temporary deployment of a telemedicine program as well. There are specific documents identified that will be useful in choosing telemedicine vendors, equipment, and software, initiating a telemedicine program, monitoring patients remotely, and developing documentation tools. There is also information that will be useful for providers who intend to care for patients through electronic virtual services that may be temporarily used during the COVID-19 pandemic.

Toolkit

Quality Payment Program and Quality Reporting Program/Value Based Purchasing Program COVID-19 Relief

On March 22, 2020, CMS announced relief for clinicians, providers, hospitals, and facilities participating in quality reporting programs in response to the 2019 Novel Coronavirus (COVID-19). This memorandum and factsheet supplements and provides additional guidance to health care providers with regard to the announcement. CMS has extended the 2019 Merit-based Incentive Payment System (MIPS) data submission deadline from March 31 by 30 days to April 30, 2020. This and other efforts are to provide relief to clinicians responding to the COVID-19 pandemic. In addition, the MIPS automatic extreme and uncontrollable circumstances policy will apply to MIPS eligible clinicians who do not submit their MIPS data by the April 30, 2020 deadline.

You can find a copy of the memo here: Memo

You can find a copy of the fact sheet here: Fact Sheet

Clinical Laboratory Improvement Amendments (CLIA) Guidance During COVID-19 Emergency

CMS issued important guidance ensuring that America's clinical laboratories are prepared to respond to the threat of the 2019 Novel Coronavirus (COVID-19.) CMS is committed to taking critical steps to ensure America's clinical laboratories are prepared to respond to the COVID-19 threat and other respiratory illnesses by implementing flexibilities around requirements for a Clinical Laboratory Improvement Amendments (CLIA) certificate during public health emergencies.

While there is no formal waiver authority under CLIA, CMS continue to exercise flexibilities under current regulations and through enforcement discretion to address temporary and remote testing sites, use of alternate specimen collection devices, and implementation of laboratory developed tests. Our hope is that this guidance provides the steps needed for all U.S. Labs wanting to apply for a CLIA certificate to test for COVID-19.

Guidance

FAQ

Trump Administration Engages America's Hospitals in Unprecedented Data Sharing

On March 29, the Centers for Medicare & Medicaid Services (CMS) sent a letter to the nation's hospitals on behalf of Vice President Pence requesting they report data in connection with their efforts to fight the 2019 Novel Coronavirus (COVID-19). Specifically, the Trump Administration is requesting that hospitals report COVID-19 testing data to the U.S. Department of Health and Human Services (HHS), in addition to daily reporting regarding bed capacity and supplies to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) COVID-19 Patient Impact and Hospital Capacity Module. CMS, the federal agency with oversight of America's Medicare-participating health care providers - including hospitals - is helping the Trump Administration obtain this critical information to help identify supply and bed capacity needs,

as well as enhance COVID-19 surveillance efforts. Hospitals will report data without personal identifying information to ensure patient privacy.

"The nation's nearly 4,700 hospitals have access to testing data that's updated daily. This data will help us better support hospitals to address their supply and capacity needs, as well as strengthen our surveillance efforts across the country," said CMS Administrator Seema Verma. "America's hospitals are demonstrating incredible resilience in this unprecedented situation and we look forward to partnering further with them going forward."

The White House Coronavirus Task Force is already collecting data from public health labs and private laboratory companies but does not have data from hospital labs that conduct laboratory testing in their hospital. This hospital data is needed at the federal level to support the Federal Emergency Management Agency (FEMA) and CDC in their efforts to support states and localities in addressing and responding to the virus.

Academic, University and Hospital "in-house" labs are performing thousands of COVID-19 tests each day, but unlike private laboratories, the full results are not shared with government agencies working to track and analyze the virus. By sharing this critical data, hospitals can help Federal and state government mitigate the effects of COVID-19 and direct needed resources from Federal Emergency Management Agency (FEMA) and the U.S. Government during this unprecedented crisis.

In Vice President Pence's letter to America's hospitals, he asks all hospitals to report data on COVID-19 testing performed in their "in-house" laboratories, which are hospitals' onsite laboratories. To monitor the rapid emergence of COVID-19 and the impact on the health care system, the White House Coronavirus Task Force is requesting hospitals to report testing data to HHS each day and to the CDC's NHSN. This new data request by the Trump Administration will help monitor the spread of severe COVID-19 illness and death as well as the impact to our nation's hospitals. Because private and commercial laboratories already report, this letter is not applicable to them.

This action, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit https://www.coronavirus.gov/. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

MLN Connects Special Edition - March 31, 2020 - COVID-19: Regulatory Changes, Telehealth Billing, and Specimen Collection Codes

Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Health Care System Address COVID-19 Patient Surge

At President Trump's direction, the Centers for Medicare & Medicaid Services (CMS) issued an unprecedented array of temporary regulatory waivers and new rules to equip the American health care system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. CMS sets and enforces essential quality and safety standards for the nation's health care system and is the nation's largest health insurer serving more than 140 million Americans through Medicare, Medicaid, the Children's Health Insurance Program, and Federal Exchanges.

Made possible by President Trump's recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. health care system for the duration of the emergency declaration. This allows hospitals and health systems to deliver services at other locations to make room for COVID-19 patients needing acute care in their main facility.

The changes complement and augment the work of FEMA and state and local public health authorities by empowering local hospitals and health care systems to rapidly expand treatment capacity that allows them to separate patients infected with COVID-19 from those who are not affected. CMS's waivers and flexibilities will permit hospitals and health care systems to expand capacity by triaging patients to a variety of community-based locales, including ambulatory surgery centers, inpatient rehabilitation hospitals, hotels, and dormitories. Transferring uninfected patients will help hospital staffs to focus on the most critical COVID-19 patients, maintain infection control protocols, and conserve Personal Protective Equipment (PPE).

"Every day, heroic nurses, doctors, and other health care workers are dedicating long hours to their patients. This means sacrificing time with their families and risking their very lives to care for coronavirus patients," said CMS Administrator Seema Verma. "Front line health care providers need to be able to focus on patient care in the most flexible and innovative ways

possible. This unprecedented temporary relaxation in regulation will help the health care system deal with patient surges by giving it tools and support to create non-traditional care sites and staff them quickly."

CMS's announcement will also waive certain requirements to enable and encourage hospitals to hire local physicians and other providers to address potential surges. New rules allow hospitals to support physician practices by transferring critical equipment, including items used for telehealth, as well as providing meals and childcare for their health care workers.

Other temporary CMS waivers and rule changes dramatically lessen administrative burdens, knowing that front line providers will be operating with high volumes and under extraordinary system stresses.

CMS recently approved hundreds of waiver requests from health care providers, state governments, and state hospital associations in the following states: Ohio, Tennessee, Virginia, Missouri, Michigan, New Hampshire, Oregon, California, Washington, Illinois, Iowa, South Dakota, Texas, New Jersey, and North Carolina. With this announcement of blanket waivers, other states and providers do not need to apply for these waivers and can begin using the flexibilities immediately.

Administrator Verma added that she applauds the March 23, 2020, pledge by America's Health Insurance Plans (AHIP) to match CMS's waivers for Medicare beneficiaries in areas where in-patient capacity is under strain. "It's a terrific example of public-private partnership and will expand the impact of Medicare's changes," Verma said.

CMS's temporary actions empower local hospitals and health care systems to:

Increase Hospital Capacity - CMS Hospitals Without Walls

CMS will allow communities to take advantage of local ambulatory surgery centers that have canceled elective surgeries, per federal recommendations. Surgery centers can contract with local health care systems to provide hospital services, or they can enroll and bill as hospitals during the emergency declaration as long as they are not inconsistent with their state's Emergency Preparedness or Pandemic Plan. The new flexibilities will also leverage these types of sites to decant services typically provided by hospitals such as cancer procedures, trauma surgeries, and other essential surgeries.

CMS will now temporarily permit non-hospital buildings and spaces to be used for patient care and quarantine sites, provided that the location is approved by the state and ensures the safety and comfort of patients and staff. This will expand the capacity of communities to develop a system of care that safely treats patients without COVID-19 and isolate and treat patients with COVID-19.

CMS will also allow hospitals, laboratories, and other entities to perform tests for COVID-19 on people at home and in other community-based settings outside of the hospital. This will both increase access to testing and reduce risks of exposure. The new guidance allows health care systems, hospitals, and communities to set up testing sites exclusively for the purpose of identifying COVID-19-positive patients in a safe environment.

In addition, CMS will allow hospital emergency departments to test and screen patients for COVID-19 at drive-through and off-campus test sites.

During the public health emergency, ambulances can transport patients to a wider range of locations when other transportation is not medically appropriate. These destinations include community mental health centers, federally qualified health centers, physician's offices, urgent care facilities, ambulatory surgery centers, and any locations furnishing dialysis services when an ESRD facility is not available.

Physician-owned hospitals can temporarily increase the number of their licensed beds, operating rooms, and procedure rooms. For example, a physician-owned hospital may temporarily convert observation beds to inpatient beds to accommodate patient surge during the public health emergency.

In addition, hospitals can bill for services provided outside their four walls. Emergency departments of hospitals can use telehealth services to quickly assess patients to determine the most appropriate site of care, freeing emergency space for those that need it most. New rules ensure that patients can be screened at alternate treatment and testing sites which are not subject to the Emergency Medical Labor and Treatment Act (EMTALA) as long as the national emergency remains in force. This will allow hospitals, psychiatric hospitals, and critical access hospitals to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19.

Rapidly Expand the Health Care Workforce

Local private practice clinicians and their trained staff may be available for temporary employment since nonessential medical and surgical services are postponed during the public health emergency. CMS's temporary requirements allow hospitals and health care systems to increase their workforce capacity by removing barriers for physicians, nurses, and other clinicians to be readily hired from the local community, as well as those licensed from other states without violating Medicare rules.

These health care workers can then perform the functions they are qualified and licensed for, while awaiting completion of federal paperwork requirements.

CMS is issuing waivers so that hospitals can use other practitioners, such as physician assistants and nurse practitioners, to the fullest extent possible, in accordance with a state's emergency preparedness or pandemic plan. These clinicians can perform services such as order tests and medications that may have previously required a physician's order where this is permitted under state law.

CMS is waiving the requirements that a Certified Registered Nurse Anesthetist (CRNA) is under the supervision of a physician. This will allow CRNAs to function to the fullest extent allowed by the state and free up physicians from the supervisory requirement and expand the capacity of both CRNAs and physicians.

CMS also is issuing a blanket waiver to allow hospitals to provide benefits and support to their medical staffs, such as multiple daily meals, laundry service for personal clothing, or child care services while the physicians and other staff are at the hospital and engaging in activities that benefit the hospital and its patients.

CMS will also allow health care providers (clinicians, hospitals and other institutional providers, and suppliers) to enroll in Medicare temporarily to provide care during the public health emergency.

Put Patients over Paperwork

CMS is temporarily eliminating paperwork requirements and allowing clinicians to spend more time with patients. Medicare will now cover respiratory-related devices and equipment for any medical reason determined by clinicians so that patients can get the care they need; previously Medicare only covered them under certain circumstances.

During the public health emergency, hospitals will not be required to have written policies on processes and visitation of patients who are in COVID-19 isolation. Hospitals will also have more time to provide patients a copy of their medical record.

CMS is providing temporary relief from many audit and reporting requirements so that providers, health care facilities, Medicare Advantage health plans, Medicare Part D prescription drug plans, and states can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

This is being done by extending reporting deadlines and suspending documentation requests which would take time away from patient care.

Further Promote Telehealth in Medicare

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. During the public health emergencies, individuals can use interactive apps with audio and video capabilities to visit with their clinician for an even broader range of services. Providers also can evaluate beneficiaries who have audio phones only.

These temporary changes will ensure that patients have access to physicians and other providers while remaining safely at home.

Providers can bill for telehealth visits at the same rate as in-person visits. Telehealth visits include emergency department visits, initial nursing facility and discharge visits, home visits, and therapy services, which must be provided by a clinician that is allowed to provide telehealth. New as well as established patients now may stay at home and have a telehealth visit with their provider.

CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health.

CMS is making it clear that clinicians can provide remote patient monitoring services to patients with acute and chronic conditions and for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry.

In addition, CMS is allowing physicians to supervise their clinical staff using virtual technologies when appropriate, instead of requiring in-person presence.

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

For more information on the COVID-19 waivers and guidance, and the Interim Final Rule, please go to the CMS COVID-19 flexibilities webpage: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers.

These actions, and earlier CMS actions in response to COVID-19, are part of the ongoing White House Coronavirus Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit https://www.coronavirus.gov/. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

Billing for Professional Telehealth Services During the Public Health Emergency

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth. As a reminder, CMS is not requiring the "CR" modifier on telehealth services. However, consistent with current rules for traditional telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

Traditional Medicare telehealth services professional claims should reflect the designated POS code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. There is no change to the facility/non-facility payment differential applied based on POS. Claims submitted with POS code 02 will continue to pay at the facility rate.

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing

Clinical diagnostic laboratories: To identify and reimburse specimen collection for COVID-19 testing, CMS established two Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

These codes are billable by clinical diagnostic laboratories.

MLN Connects - April 2, 2020

Interoperability and Patient Access Final Rule Call - April 7

MLN Connects® for Thursday, April 2, 2020
View this edition as a PDF

News

- IRF Provider Preview Reports: Review Your Data by April 13
- LTCH Provider Preview Reports: Review Your Data by April 13
- Hospice Provider Preview Reports: Review Your Data by April 13

Events

- Interoperability and Patient Access Final Rule Call - April 7

MLN Matters® Articles

- July 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- NCD (20.32) Transcatheter Aortic Valve Replacement (TAVR)
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - July 2020
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.2, Effective July 1, 2020
- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update - Revised
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.1, Effective April 1, 2020 - Revised

Publications

- MLN Catalog - April 2020 Edition

Multimedia

- Open Payments Call: Audio Recording and Transcript

MLN Connects Special Edition - April 3, 2020 - COVID-19: Telehealth Billing Correction, Nursing Home Recommendations, Billing for Multi-Function Ventilators, New ICD-10-CM Diagnosis Code

Billing for Professional Telehealth Distant Site Services During the Public Health Emergency - Revised

This corrects a prior message that appeared in our March 31, 2020 Special Edition.

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with:

- Place of Service (POS) equal to what it would have been had the service been furnished in-person
- Modifier 95, indicating that the service rendered was actually performed via telehealth

As a reminder, CMS is not requiring the CR modifier on telehealth services. However, consistent with current rules for telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

Trump Administration Issues Key Recommendations to Nursing Homes, State and Local Governments

On April 3, at the direction of President Trump, the Centers for Medicare & Medicaid Services (CMS), in consultation with the Centers for Disease Control and Prevention (CDC), issued critical recommendations to state and local governments, as well as

nursing homes, to help mitigate the spread of the 2019 Novel Coronavirus (COVID-19) in nursing homes. The recommendations build on and strengthen recent guidance from CMS and CDC related to effective implementation of longstanding infection control procedures.

Press Release

Guidance

Billing for Multi-Function Ventilators (HCPCS Code E0467) under the COVID-19 Public Health Emergency and Otherwise

CMS recognizes that in these important times, in particular, beneficiaries, health care clinicians, suppliers, and manufacturers are looking for the broadest possible access to ventilators for their care needs. We are taking a number of steps to increase access to and remind suppliers about certain options available to them and beneficiaries regarding multi-function ventilators.

Effective immediately, CMS is suspending claims editing for multi-function ventilators when there are claims for separate devices in history that have not met their reasonable useful lifetime.

For more information on multi-function ventilators, see MLN Matters Special Edition Article SE20012.

New ICD-10-CM diagnosis code, U07.1, for COVID-19

In response to the national emergency that was declared concerning the COVID-19 outbreak, a new diagnosis code, U07.1, COVID-19, has been implemented, effective April 1, 2020.

As a result, an updated ICD-10 MS-DRG GROUPER software package to accommodate the new ICD-10-CM diagnosis code, U07.1, COVID-19, effective with discharges on and after April 1, 2020, is available on the CMS MS-DRG Classifications and Software webpage.

This updated GROUPER software package (V37.1 R1) replaces the GROUPER software package V37.1 that was developed in response to the new ICD-10-CM diagnosis code U07.0, Vaping-related disorder, also effective with discharges on and after April 1, 2020, that is currently available on the MS-DRG Classifications and Software webpage.

Providers should use this new code, U07.1, where appropriate, for discharges on or after April 1, 2020. Refer to the updated MLN Matters Articles for additional Medicare Fee-For-Service information:

- Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder and 2019 Novel Coronavirus (COVID-19)
- Update to the Home Health Grouper for New Diagnosis Codes for Vaping Related Disorder and COVID-19
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1 R1

For detailed information regarding the assignment of new diagnosis code U07.1, COVID-19, under the ICD-10 MS-DRGs, visit the MS-DRG Classifications and Software webpage. The announcement is located under the "Latest News" heading.

For additional information related to the new COVID-19 diagnosis code, visit the CDC website.

MLN Connects Special Edition - April 7, 2020 - COVID-19: Telehealth Video, Coinsurance and Deductible Waived, ASC Attestations, Ambulance Modifiers, Lessons From Front Lines, MLN Call Today

New Video Available on Medicare Coverage and Payment of Virtual Services

CMS released a video providing answers to common questions about the Medicare telehealth services benefit. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

Video

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

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

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

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

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

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

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

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

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

Additional CMS actions in response to COVID-19, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit https://www.coronavirus.gov/. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

Guidance for Processing Attestations from Ambulatory Surgical Centers (ASCs) Temporarily Enrolling as Hospitals during the COVID-19 Public Health Emergency

CMS is providing needed flexibility to hospitals to ensure they have the ability to expand capacity and to treat patients during the COVID-19 public health emergency. As part of the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers CMS is allowing Medicare-enrolled ASCs to temporarily enroll as hospitals and to provide hospital services to help address the urgent need to increase hospital capacity to take care of patients.

Guidance

COVID-19: Expanded Use of Ambulance Origin/Destination Modifiers

During the COVID-19 Public Health Emergency, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished. On an interim basis, we are expanding the list of destinations that may include but are not limited to:

- Any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH), or Skilled Nursing Facility (SNF)

- Community mental health centers
- Federally Qualified Health Centers (FQHCs)
- Rural health clinics (RHCs)
- Physicians' offices
- Urgent care facilities
- Ambulatory Surgery Centers (ASCs)
- Any location furnishing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when an ESRD facility is not available
- Beneficiary's home

CMS expanded the descriptions for these origin and destination claim modifiers to account for the new covered locations:

- Modifier D - Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
- Modifier E - Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the beneficiary's home
- Modifier H - Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
- Modifier N - Alternative care site for SNF
- Modifier P - Physician's office
- Modifier R - Beneficiary's home

For the complete list of ambulance origin and destination claim modifiers see Medicare Claims Processing Manual Chapter 15, Section 30 A.

Lessons from The Front Lines: COVID-19

On April 3, CMS Administrator Seema Verma, Deborah Birx, MD, White House Coronavirus Task Force, and officials from the FDA, CDC, and FEMA participated in a call on **COVID-19 Flexibilities**. Several physician guests on the front lines presented best practices from their COVID-19 experiences. You can listen to the conversation here.

CMS COVID-19 Update Call Today

Tuesday, April 7 from 2 to 3 pm ET

Register for Medicare Learning Network events. Registration closes at 12pm ET.

CMS update on recent actions taken to address the COVID-19 public health emergency.

Target Audience: All Medicare fee-for-service providers and interested stakeholders.

MLN Connects® for Thursday, April 9, 2020

Important COVID-19 Updates

MLN Connects® for Thursday, April 9, 2020
View this edition as a PDF

News

- CMS Approves Approximately $34 Billion for Providers with the Accelerated/Advance Payment Program for Medicare Providers in One Week
- COVID-19: Dear Clinician Letter
- COVID-19: Non-Emergent, Elective Medical Services and Treatment Recommendations
- Quality Payment Program: MIPS Extreme and Uncontrollable Circumstances Policy in Response to COVID-19
- Multi-Factor Authentication Requirement Delayed for PECOS, I&A, and NPPES
- Open Payments: Pre-Publication Review and Dispute through May 15

Claims, Pricers & Codes

- Pneumococcal Pneumonia Vaccination: Eligibility Transactions Includes DOS Starting April 13

Events

- Ground Ambulance Organizations: Data Collection for Medicare Providers Call - May 7

MLN Matters® Articles

- Supplier Education on Use of Upgrades for Multi-Function Ventilators
- Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) - Revised

Publications

- Civil Rights, HIPAA, and COVID-19
- Medicare Advance Written Notices of Noncoverage - Revised
- Medicare Preventive Services - Revised
- Medicare Preventive Services Poster - Revised

MLN Connects Special Edition - April 10, 2020 - COVID-19: Infection Control, Maximizing Workforce, Updated Q&A, CS Modifier for Cost-Sharing, Payment Adjustment Suspended

CMS Issues New Wave of Infection Control Guidance to Protect Patients and Healthcare Workers from COVID-19

CMS issued a series of updated guidance documents focused on infection control to prevent the spread of the 2019 Novel Coronavirus (COVID-19) in a variety of inpatient and outpatient care settings. The guidance, based on Centers for Disease Control and Prevention (CDC) guidelines, will help ensure infection control in the context of patient triage, screening and treatment, the use of alternate testing and treatment sites and telehealth, drive-through screenings, limiting visitations, cleaning and disinfection guidelines, staffing, and more.

Press Release

Trump Administration Acts to Ensure U.S. Healthcare Facilities Can Maximize Frontline Workforces to Confront COVID-19 Crisis

At President Trump's direction, the Centers for Medicare & Medicaid Services (CMS) today temporarily suspended a number of rules so that hospitals, clinics, and other healthcare facilities can boost their frontline medical staffs as they fight to save lives during the 2019 Novel Coronavirus (COVID-19) pandemic.

These changes affect doctors, nurses, and other clinicians nationwide, and focus on reducing supervision and certification requirements so that practitioners can be hired quickly and perform work to the fullest extent of their licenses. The new waivers sharply expand the workforce flexibilities CMS announced on March 30.

For a fact sheet detailing additional information on the waivers announced today and previously, go to: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Updated Questions and Answers on COVID-19

Review CMS' updated FAQs to equip the American health care system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Check this resource often as CMS updates it on a regular basis - we insert the date at the end of each FAQ when it is new or updated.

Using CS Modifier When Cost-Sharing is Waived

This clarifies a prior message that appeared in our April 7, 2020 Special Edition.

CMS now waives cost-sharing (coinsurance and deductible amounts) under Medicare Part B for Medicare patients for certain COVID-19 testing-related services. Previously, CMS made available the CS modifier for the gulf oil spill in 2010; however, CMS recently repurposed the CS modifier for COVID-19 purposes. Now, for services furnished on March 18, 2020, and through the end of the Public Health Emergency, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under specific payment systems outlined in the April 7 message should use the CS modifier on applicable claim

lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and to get 100% of the Medicare-approved amount. Additionally, they should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

Medicare FFS Claims: 2% Payment Adjustment Suspended (Sequestration)

Section 3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act temporarily suspends the 2% payment adjustment currently applied to all Medicare Fee-For-Service (FFS) claims due to sequestration. The suspension is effective for claims with dates of service from May 1 through December 31, 2020.

MLN Connects Special Edition - April 15, 2020 - COVID-19: Reprocessing Hospital Claims, Essential Diagnostic Services, Non-Invasive Ventilators

IPPS Hospitals, LTCHs: Reprocessing Claims for CARES Act

CMS is implementing changes to increase payments to Inpatient Prospective Payment System (IPPS) hospitals and Long-Term Care Hospitals (LTCHs) under Sections 3710 and 3711 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. When you submit an IPPS claim for discharges on or after January 27, 2020, or an LTCH claim for admissions on or after January 27, 2020, and we receive it:

- April 20, 2020, and earlier, Medicare will reprocess. You do not need to take any action.
- On or after April 21, 2020, Medicare will process in accordance with the CARES Act.

For more information, see MLN Matters Special Edition Article SE20015.

Trump Administration Announces Expanded Coverage for Essential Diagnostic Services Amid COVID-19 Public Health Emergency

CMS, together with the Departments of Labor and the Treasury, issued guidance to ensure Americans with private health insurance have coverage of COVID-19 diagnostic testing and certain other related services, including antibody testing, at no cost. This includes urgent care visits, emergency room visits, and in-person or telehealth visits to the doctor's office that result in an order for or administration of a COVID-19 test. As part of the effort to slow the spread of the virus, this guidance is another action the Trump Administration is taking to remove financial barriers for Americans to receive necessary COVID-19 tests and health services, as well as encourage the use of antibody testing that may help to enable health care workers and other Americans to get back to work more quickly.

Press Release

Guidance

Removal of Non-Invasive Ventilator Product Category from DMEPOS Competitive Bidding Program

CMS is removing the non-invasive ventilator (NIV) product category from Round 2021 of the DMEPOS Competitive Bidding Program due to the novel COVID-19 pandemic, the President's exercise of the Defense Production Act, public concern regarding access to ventilators, and the NIV product category being new to the DMEPOS Competitive Bidding Program.

DME Competitive Bidding Program

MLN Connects - April 16, 2020

3 Proposed Payment Rules

MLN Connects® for Thursday, April 16, 2020
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News

- Hospice Payment Rate Update Proposed Rule for FY 2021
- IPF Prospective Payment System Proposed Rule for FY 2021

- SNF Proposed Payment and Policy Changes for FY 2021

Events

- Ground Ambulance Organizations: Data Collection for Medicare Providers Call - May 7

MLN Matters® Articles

- April 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Quarterly Update to the Fiscal Year 2020 Inpatient Psychiatric Facilities Pricer
- Claim Status Category and Claim Status Codes Update - Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment - Revised

Publications

- Inpatient Rehabilitation Facility Prospective Payment System - Revised
- Medicare Overpayments - Revised
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services- Revised

Multimedia

- Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training Course - Revised
- Medicare Part C and Part D Data Validation Web-Based Training Course - Revised

MLN Connects Special Edition - April 17, 2020 - COVID-19: RHC & FQHC Flexibilities, Increased Payment for Lab Tests, Hospital Waivers, Call Audio and Transcript

RHC & FQHC Flexibilities During COVID-19 Public Health Emergency

To support Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and their patients, Congress and CMS made changes to requirements and payments during the COVID-19 Public Health Emergency. See MLN Matters Special Edition Article 20016 to learn about:

- New payment for telehealth services, including how to bill Medicare
- Expansion of virtual communication services
- Revision of home health agency shortage requirement for visiting nursing services
- Consent for care management and virtual communication services
- Accelerated/advance payments

CMS Increases Medicare Payment for High-Production Coronavirus Lab Tests

CMS announced that Medicare will nearly double payment for certain lab tests that use high-throughput technologies to rapidly diagnose large numbers of COVID-19 cases. This is another action the Trump Administration is taking to rapidly expand COVID-19 testing. Along with the March 30 announcement that Medicare will pay new specimen collection fees for COVID-19 testing, CMS's actions will expand capability to test more vulnerable populations, like nursing home patients, quickly and provide results faster. Medicare will pay laboratories for the tests at $100 effective April 14, 2020, through the duration of the COVID-19 national emergency.

Press Release

CMS Implements CARES Act Hospital Payment and Inpatient Rehabilitation Facility Waivers

The Coronavirus Aid, Relief, and Economic Security (CARES) Act increases payment for Inpatient Prospective Payment System (IPPS) and long-term care hospital (LTCH) inpatient hospital care attributable to COVID-19. CMS provided guidance for IPPS hospitals and LTCHs on how to code claims to receive the higher payment.

The CARES Act also waives the requirement that Medicare Part A fee-for-service patients treated in inpatient rehabilitation facilities receive at least 15 hours of therapy per week.

MLN Matters Article

Emergency Declaration Waivers Summary

COVID-19 Call: Audio Recording and Transcript

An audio recording and transcript are available for the April 7 Medicare Learning Network call on 2019 Novel Coronavirus (COVID-19) Updates. Learn about CMS waivers and COVID-19 response.

MLN Connects - April 23, 2020

Report Clinical Trial Data to Fight COVID-19 & Earn MIPS Credit

MLN Connects® for Thursday, April 23, 2020
View this edition as a PDF

News

- Trump Administration Champions Reporting of COVID-19 Clinical Trial Data through Quality Payment Program, Announces New Clinical Trials Improvement Activity
- CMS Releases Additional Blanket Waivers for Long-Term Care Hospitals, Rural Health Clinics, Federally Qualified Health Centers and Intermediate Care Facilities
- IRF PPS FY 2021 Proposed Rule
- Bill Correctly for Inhalant Drugs

Events

- Ground Ambulance Organizations: Data Collection for Medicare Providers Call - May 7

MLN Matters® Articles

- New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)
- New Waived Tests
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1 - Revised
- April 2020 Update of the Ambulatory Surgical Center (ASC) Payment System - Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update - Revised
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update - Revised
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update - Revised

Publications

- Provider Compliance Tips for Nebulizers and Related Drugs Fact Sheet - Revised

Multimedia

- Medicare Home Health Benefit Web-Based Training Course - Revised

MLN Connects Special Edition - April 27, 2020 - CMS Reevaluates Accelerated Payment Program and Suspends Advance Payment Program

On April 26, the Centers for Medicare & Medicaid Services (CMS) announced that it is reevaluating the amounts that will be paid under its Accelerated Payment Program and suspending its Advance Payment Program to Part B suppliers effective immediately. The agency made this announcement following the successful payment of over $100 billion to health care providers and suppliers through these programs and in light of the $175 billion recently appropriated for health care provider relief payments.

CMS had expanded these temporary loan programs to ensure providers and suppliers had the resources needed to combat the beginning stages of the 2019 Novel Coronavirus (COVID-19). Funding will continue to be available to hospitals and other health care providers on the front lines of the coronavirus response primarily from the Provider Relief Fund. The Accelerated and Advance Payment (AAP) Programs are typically used to give providers emergency funding and address cash flow issues for providers and suppliers when there is disruption in claims submission or claims processing, including during a public health emergency or Presidentially-declared disaster.

Since expanding the AAP programs on March 28, 2020, CMS approved over 21,000 applications totaling $59.6 billion in payments to Part A providers, which includes hospitals. For Part B suppliers, including doctors, non-physician practitioners and durable medical equipment suppliers, CMS approved almost 24,000 applications advancing $40.4 billion in payments. The AAP programs are not a grant, and providers and suppliers are typically required to pay back the funding within one year, or less, depending on provider or supplier type. Beginning today, CMS will not be accepting any new applications for the Advance Payment Program, and CMS will be reevaluating all pending and new applications for Accelerated Payments in light of historical direct payments made available through the Department of Health & Human Services' (HHS) Provider Relief Fund.

Significant additional funding will continue to be available to hospitals and other health care providers through other programs. Congress appropriated $100 billion in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (PL 116-136) and $75 billion through the Paycheck Protection Program and Health Care Enhancement Act (PL 116-139) for health care providers. HHS is distributing this money through the Provider Relief Fund, and these payments do not need to be repaid.

The CARES Act Provider Relief Fund is being administered through HHS and has already released $30 billion to providers and is in the process of releasing an additional $20 billion, with more funding anticipated to be released soon. This funding will be used to support health care-related expenses or lost revenue attributable to the COVID-19 pandemic and to ensure uninsured Americans can get treatment for COVID-19.

For more information on the CARES Act Provider Relief Fund and how to apply, visit: hhs.gov/providerrelief.

For an updated fact sheet on the Accelerated and Advance Payment Programs, visit: https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf.

MLN Connects - April 30, 2020

COVID-19: Lessons from the Front Lines

MLN Connects® for Thursday, April 30, 2020
View this edition as a PDF

News

- Infection Control Guidance to Home Health Agencies on COVID-19
- Now Available: Nursing Home Five Star Quality Rating System Updates, Nursing Home Staff Counts, and Frequently Asked Questions
- CMS Adds New COVID-19 Clinical Trials Improvement Activity to the Quality Payment Program
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- Home Health Claims: Correcting Recoding Errors

Events

- COVID-19: Lessons from the Front Lines Calls - May 1 and 8
- COVID-19: Home Health and Hospice Call - May 5
- COVID-19: Office Hours Call - May 5
- COVID-19: Nursing Homes Call - May 6

MLN Matters® Articles

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

Pricer
- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendment (CLIA) Edits - Revised
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE - Revised

Publications

- April 2020 Medicare Quarterly Provider Compliance Newsletter
- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants - Revised
- Ambulatory Surgical Center Payment System - Revised
- Dual Eligible Beneficiaries Under Medicare and Medicaid - Revised
- Hospital Outpatient Prospective Payment System - Revised
- How to Use the Searchable Medicare Physician Fee Schedule - Revised
- Long-Term Care Hospital Prospective Payment System - Revised

Multimedia

- Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training Course - Revised
- Medicare Parts C and D General Compliance Training Web-Based Training Course - Revised

MLN Connects Special Edition - April 30, 2020 - COVID-19: Second Round of Sweeping Changes, RHC & FQHC Flexibilities, EMTALA

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

At President Trump's direction, and building on its recent historic efforts to help the U.S. healthcare system manage the 2019 Novel Coronavirus (COVID-19) pandemic, on April 30, 2020, the Centers for Medicare & Medicaid Services, issued another round of sweeping regulatory waivers and rule changes to deliver expanded care to the nation's seniors and provide flexibility to the healthcare system as America reopens. These changes include making it easier for Medicare and Medicaid beneficiaries to get tested for COVID-19 and continuing CMS's efforts to further expand beneficiaries' access to telehealth services.

Full press release

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

A revised MLN Matters Special Edition Article SE20016 on New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE) is available. Learn new information on billing for distant site telehealth services during the COVID-19 PHE, including:

- New telehealth services that can be provided by RHCs and FQHCs, including audio only telephone evaluation and management services
- Revised bed count methodology for determining the exemption to the RHC payment limit for provider-based RHCs

New Frequently Asked Questions on EMTALA

CMS issued Frequently Asked Questions (FAQs) clarifying requirements and considerations for hospitals and other providers related to the Emergency Medical Treatment and Labor Act (EMTALA) during the COVID-19 pandemic. The FAQs address questions around patient presentation to the emergency department, EMTALA applicability across facility types, qualified medical professionals, medical screening exams, patient transfer and stabilization, telehealth, and other topics.

Frequently Asked Questions

MLN Connects - May 7, 2020

More COVID-19 Updates

MLN Connects® for Thursday, May 7, 2020
View this edition as a PDF

News

- CMS Announces Independent Commission to Address Safety and Quality in Nursing Homes
- Home Health Plans of Care: NPs, CNSs and PAs Allowed to Certify
- Health Care Supply Chain, Provider Self-Care, and Emergency Preparedness Resources

Claims, Pricers & Codes

- COVID-19: Modified Ordering Requirements for Laboratory Billing
- Hospital OPPS: New Coronavirus Specimen Collection Code

Events

- COVID-19: Office Hours Call - May 7
- COVID-19: Lessons from the Front Lines Calls - May 8

MLN Matters® Articles

- Addition of the QW modifier to Healthcare Common Procedure Coding System (HCPCS) code U0002 and 87635
- Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan
- New Codes for Therapist Assistants Providing Maintenance Programs in the Home Health Setting
- Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy - Revised

Publications

- Evaluation and Management Services - Revised

MLN Connects Special Edition - May 8, 2020 - COVID-19: Nursing Home Reporting, Updated Telehealth Video, Pharmacies & Other Suppliers Can Enroll as Labs, IRF Flexibilities

New Guidance Available on Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes

Nursing homes are now required to report the first week of COVID-19 data to the Centers for Disease Control and Prevention (CDC) beginning May 8 but no later than May 17. For the first time, all 15,000 nursing homes will be reporting this data directly to the CDC through its reporting tool. This reporting requirement is the first action of its kind in the agency's history. On April 19, CMS announced the agency would be requiring facilities to report COVID-19 information to the CDC and to families. Within three weeks of that announcement, on April 30, CMS issued an Interim Final Rule with Comment Period with the new regulatory requirements. As nursing homes report this data to the CDC, we will be taking swift action and publicly posting this information so all Americans have access to accurate and timely information on COVID-19 in nursing homes.

CMS has a longstanding requirement for nursing homes to report cases of communicable diseases, such as COVID-19, to the appropriate state or local health department. This new requirement not only helps health departments intervene when needed but serves to provide awareness to the public (e.g., families) and surveillance for public health agencies and the CDC. The importance of ongoing transparency and information sharing has proven to be one of the keys to the battle against this pandemic. Building upon the successes of the Trump Administration prior to COVID-19, CMS has strongly supported transparency, such as the work done over the past several years to improve public access and understanding of nursing home inspection reports and expand the information available to consumers on Nursing Home Compare. The agency remains committed to greater transparency and plans to publicly release new data by the end of May. CMS will never stop working to give patients, residents, and families the clearest and most accurate information possible.

Guidance and Frequently Asked Questions

Telehealth Video: Medicare Coverage and Payment of Virtual Services

This updated video provides answers to common questions about the expanded Medicare telehealth services benefit under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

Medicare Pharmacies and Other Suppliers May Temporarily Enroll as Independent Clinical Diagnostic Laboratories to Help Address COVID-19 Testing MLN Matters® Article

A new MLN Matters Special Edition Article SE20017 on Medicare Pharmacies and Other Suppliers May Temporarily Enroll as Independent Clinical Diagnostic Laboratories to Help Address COVID-19 Testing is available. Learn how to temporarily enroll to be an additional laboratory resource to meet the urgent need to increase COVID-19 testing capability.

COVID-19: IRF Flexibilities During the PHE

CMS is exercising regulatory flexibilities for Inpatient Rehabilitation Facilities (IRFs) during the COVID-19 Public Health Emergency (PHE) to waive the 60 percent rule.

We are also waiving IRF coverage and classification requirements if all of these criteria are satisfied:

- Patient is admitted to a freestanding IRF to alleviate acute care hospital bed capacity issues
- IRF is located in an area that is in Phase 1 or has not entered Phase 1; see Guidelines for Opening Up America Again

Add the following letters at the end of your unique hospital patient identification number (the number that identifies the patient's medical record in the IRF) to identify patients eligible for each waiver:

- D- 60 percent rule
- DS- Coverage and classification requirements
- DDS- Both 60 percent rule and coverage and classification requirements

For More Information:

- COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers: See page 10 for 60 percent rule
- Interim Final Rule: Coverage and classification requirements

COVID-19: IRF Interdisciplinary Team Meetings During the Pandemic

CMS expects Inpatient Rehabilitation Facilities (IRFs) to hold in-person weekly interdisciplinary team meetings to discuss Medicare Part A fee-for-service patients. During the public health emergency, it may be safest to conduct meetings electronically. We will accept all appropriate forms of social distancing precautions.

MLN Connects Special Edition - May 12, 2020 - COVID-19: Additional Waivers, Price Transparency, and CMS Letter to Nursing Homes

CMS Releases Additional Waivers for Hospitals and Other Facilities

CMS continues to release waivers for the health care community that provide the flexibilities needed to take care of patients during the COVID-19 Public Health Emergency (PHE). CMS recently provided additional blanket waivers for the duration of the PHE that:

- Expand hospitals' ability to offer long-term care services ("swing beds")
- Waive distance requirements, market share, and bed requirements for Sole Community Hospitals
- Waive certain eligibility requirements for Medicare-Dependent, Small Rural Hospitals (MDHs)
- Update specific life safety code requirements for hospitals, hospice, and long-term care facilities

For more information, see Emergency Declaration Blanket Waivers.

Price Transparency: Requirement to Post Cash Prices Online for COVID-19 Diagnostic Testing

The Coronavirus Aid, Relief, and Economic Security (CARES) Act includes a number of provisions to provide relief to the public from issues caused by the pandemic, including price transparency for COVID -19 testing. Section 3202(b) of the CARES Act

requires providers of diagnostic tests for COVID-19 to post the cash price for a COVID-19 diagnostic test on their website from March 27 through the end of the public health emergency. For more information, see the FAQs.

CMS Letter to Nursing Home Facility Management and Staff

On May 11, CMS Administrator Seema Verma penned a letter to nursing home management and staff. Administrator Verma shared her gratitude for the unwavering dedication and commitment of nursing home management and staff in keeping residents safe and for continuing to compassionately care for those who rely on them during this unprecedented time. The letter also provides links to previously shared infection control resources.

MLN Connects - May 14, 2020

IPPS/LTCH PPS: FY 2021 Proposed Rule

MLN Connects® for Thursday, May 14, 2020
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News

- IPPS and LTCH PPS: FY 2021 Proposed Rule
- Medicare FFS 2nd Level Appeals: Submission Options

Events

- COVID-19: Office Hours Call - May 14
- COVID-19: Lessons from the Front Lines Call - May 15

MLN Matters® Articles

- Medicare Clarifies Recognition of Interstate License Compacts
- Extension of Payment for Section 3712 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act)
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - October 2020 Update
- Updates to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) to Correct the Adjustment Process
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update - Revised

Publications

- How to Use the Medicare Coverage Database - Revised

MLN Connects Special Edition - May 19, 2020 - COVID-19: Payment for Lab Tests, Safely Reopening Nursing Homes, Lab & Ambulance Claims

COVID-19: Payment for Diagnostic Laboratory Tests

Earlier this year, CMS took action to ensure America's patients, health care facilities, and clinical laboratories were prepared to respond to the 2019-Novel Coronavirus (COVID-19). To help increase testing and track new cases, CMS developed two HCPCS codes that laboratories can use to bill for certain COVID-19 diagnostic tests. Health care providers and laboratories may bill Medicare and other health insurers for SARS-CoV2 tests performed on or after February 4 using:

- HCPCS code U0001 for tests developed by the Centers for Disease Control and Prevention (CDC)
- HCPCS code U0002 for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19)

Laboratories and other health providers can also bill Medicare for tests using CPT codes created by the American Medical Association, provided testing uses the method specified by each CPT code:

- CPT code 87635 for infectious agent detection by nucleic acid tests for dates of service on or after March 13
- CPT codes 86769 and 86328 for serology tests for dates of service on or after April 10

Finally, for dates of service on or after April 14, 2020, Medicare pays $100 for laboratory tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 making use of high throughput technologies. Laboratories can bill Medicare for these tests using:

- 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.
- 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.

Neither U0003 nor U0004 should be used to bill for tests that detect COVID-19 antibodies.

For COVID-19 tests that do not use high throughput technology, Medicare Administrative Contractors developed payment amounts for claims in their jurisdictions that will be used until we establish national payment rates though the annual laboratory meeting process. There is no cost-sharing for Medicare patients.

Trump Administration Issues Guidance to Ensure States Have a Plan in Place to Safely Reopen Nursing Homes

On May 18, under the leadership of President Trump, CMS announced new guidance for state and local officials to ensure the safe reopening of nursing homes across the country. The guidance released is part of President Trump's Guidelines for Opening Up America Again. The recommendations issued would allow states to make sure nursing homes are continuing to take the appropriate and necessary steps to ensure resident safety and are opening their doors when the time is right. This also serves to help states and nursing homes reunite families with their loved ones in a safe, phased manner.

Press Release

COVID-19: Which Laboratory Claims Require the NPI of the Ordering/Referring Professional?

During the COVID-19 Public Health Emergency, CMS is relaxing billing requirements for a limited number of laboratory tests required for a COVID-19 diagnosis. Any health care professional authorized under state law may order these tests. Medicare will pay for these tests without a written order from the treating physician or other practitioner:

- If an order is not written, you do not need to provide the National Provider Identifier (NPI) of the ordering or referring professional on the claim
- If an order is written, include the NPI of the ordering or referring professional, consistent with current billing guidelines

For More Information:

- Laboratory Tests with modified requirements
- Interim Final Rule

COVID-19: Ambulance Claims for Alternative Sites

During the COVID-19 Public Health Emergency, Medicare covers medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished.

Medicare Administrative Contractors are now processing claims according to the details provided in the April 7 message. If you believe that your previously processed claims were denied in error, contact your Medicare Administrative Contractor to have these claims reprocessed.

MLN Connects - May 21, 2020

Join Upcoming COVID-19 Calls

MLN Connects® for Thursday, May 21, 2020
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News

- CMS Releases Additional Waivers for Hospitals and Ground Ambulance Organizations
- Hospice Quality Reporting Program: Quarterly Update for January - March
- Nursing Home Quality Initiative: Updated MDS 3.0 Item Sets
- Hospitals: Submit Medicare GME Affiliation Agreements by October 1 During the COVID-19 PHE

Events

- COVID-19: Lessons from the Front Lines Calls - May 22 and 29
- COVID-19: Home Health and Hospice Call - May 26
- COVID-19: Office Hours Call - May 26
- COVID-19: Nursing Home Call - May 27
- COVID-19: Dialysis Organization Call - May 27
- COVID-19: Nurses Call - May 28
- Prior Authorization Process and Requirements for Certain Outpatient Hospital Department Services Special Open Door Forum - May 28

MLN Matters® Articles

- COVID-19 Blanket Swing Bed Waiver for Addressing Barriers to Nursing Home Placement for Hospitalized Individuals
- Manual Update to Pub. 100-04, Chapter 38, to Remove Identification of Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico Section
- National Coverage Determination (NCD) 20.19 Ambulatory Blood Pressure Monitoring (ABPM)
- National Coverage Determination (NCD 30.3.3): Acupuncture for Chronic Low Back Pain (cLBP)
- New Physician Specialty Code for Micrographic Dermatologic Surgery (MDS) and Adult Congenital Heart Disease (ACHD) and a New Supplier Specialty Code for Home Infusion Therapy Services
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2020 Update
- Therapy Codes Update

Multimedia

- Procedure Coding: Using the ICD-10-PCS Web-Based Training Course - Revised

MLN Connects - May 28, 2020

COVID-19: Adjusting Operations to Manage Patient Surge

MLN Connects® for Thursday, May 28, 2020
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News

- COVID-19: Adjusting Operations to Manage Patient Surge
- PECOS/NPPES/EHR Identity & Access Management System: Role Renamed
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- COVID-19: Lessons from the Front Lines Call - May 29

MLN Matters® Articles

- Medicare Continues to Modernize Payment Software

Publications

- Acute Care Hospital Inpatient Prospective Payment System - Revised

MLN Connects Special Edition - May 29, 2020 - New COVID-19 FAQs on Medicare Fee-for-Service Billing

CMS released additional Frequently Asked Questions (FAQs) on our recent COVID-19-related waivers to help providers, including physicians, hospitals, and rural health clinics. Find more answers to questions on:

- Outpatient therapy
- Telehealth and appropriate coding
- Federally qualified health centers

Bookmark this document and check back for additional updates.

For More Information:

- Coronavirus.gov
- CMS Current Emergencies website

Immediate Infusion of $30 Billion into Health Care System

Recognizing the importance of delivering funds in a fast and transparent manner, $30 billion is being distributed immediately through a program administered by the Department of Health and Human Services - with payments arriving via direct deposit beginning April 10, 2020 - to eligible providers throughout the American health care system. These payments are unrelated to the Accelerated and Advanced Payments you may have requested from Medicare.

The automatic payments will come from Optum Bank with "HHSPAYMENT" as the payment description.

Find more information about these payments at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html.

Condition of Payment Prior Authorization Program Expands to Include Lower Limb Prosthetics

In December 2016, CMS issued a final rule that established a Condition of Payment Prior Authorization (COPPA) process for certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) that are frequently subject to unnecessary utilization. This process was implemented in March 2017 for two HCPCS codes and expanded to include 45 items as of July 2019.

In November 2019, CMS harmonized previous rulings to create a Master List of DMEPOS items that can be subject to Prior Authorization (PA) and/or Face to Face encounter and Written Order Prior to Delivery per Final Rule 1713-F *Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule Amounts, DMEPOS Competitive Bidding Program (CBP) Amendments, Standard Elements for a DMEPOS Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Order Prior to Delivery and/or Prior Authorization Requirements.*

From this Master List, the following Lower Limb Prosthetic (LLP) HCPCS codes will be added to the COPPA list: L5856, L5857, L5858, L5973, L5980, and L5987 for beneficiaries residing in California, Michigan, Pennsylvania and Texas.

DME MACs will begin accepting LLP PA requests under the COPPA program April 27, 2020 for planned dates of service on/after May 11, 2020.

See the Required Prior Authorization Programs webpage for information on PA request submission and education resources.

RARC, CARC, MREP and PC Print Update - Revised

MLN Matters Number: MM11638 Revised
Related CR Release Date: April 15, 2020
Related CR Transmittal Number: R10052CP
Related Change Request (CR) Number: 11638
Effective Date: July 1, 2020
Implementation Date: July 6, 2020

Note: CMS revised this article on April 16, 2020, to reflect an updated Change Request (CR) 11638 that revised the WPC website address in the background section of the CR (page 2 in this article). All other information remains the same.

CR 11638 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) maintainers to update 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 versions if they use that software.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11638.

RARC, CARC, MREP and PC Print Update - Revised

MLN Matters Number: MM11489 Revised
Related CR Release Date: April 16, 2020
Related CR Transmittal Number: R10054CP
Related Change Request (CR) Number: 11489
Effective Date: April 1, 2020
Implementation Date: April 6, 2020

Note: CMS revised this article on April 16, 2020, to reflect an updated Change Request (CR) 11489 that revised the WPC website address in the background section of the CR (page 2 in this article). All other information remains the same.

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.

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM11708
Related CR Release Date: May 22, 2020
Related CR Transmittal Number: R10149CP
Related Change Request (CR) Number: 11708
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

CR 11708 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the Viable Information Processing System (ViPS) Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update Medicare Remit Easy Print (MREP) and PC Print. Make sure your billing staffs are aware of these updates. If they use the MREP or PC Print software, they will need to get the updates of that software.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11708.

Claim Status Category and Claim Status Codes Update - Revised

MLN Matters Number: MM11467 Revised
Related CR Release Date: April 9, 2020
Related CR Transmittal Number: R10044CP
Related Change Request (CR) Number: 11467
Effective Date: April 1, 2020
Implementation Date: April 6, 2020

Note: CMS revised this article on April 10, 2020, to reflect a revised Change Request (CR) 11467. CR 11467 was revised to update the Uniform Resource Locators (URLs) references (page 2 in this article) in Background Section in the CR. The CR release date, transmittal number and link to the transmittal were also changed. All other information remains the same. All other information remains the same.

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.

Claim Status Category Codes and Claim Status Codes Update

MLN Matters Number: MM11699
Related CR Release Date: May 22, 2020
Related CR Transmittal Number: R10148CP
Related Change Request (CR) Number: 11699
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

CR 11699 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)11699.

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE - Revised

MLN Matters Number: MM11490 Revised
Related CR Release Date: April 23, 2020
Related CR Transmittal Number: R10064CP
Related Change Request (CR) Number: 11490
Effective Date: April 1, 2020
Implementation Date: April 6, 2020

Note: CMS revised this article on April 23, 2020, to reflect the revised CR11490 issued on April 23, 2020. The CR revision updated the WPC website address and the same change is made to this article. In the article, CMS also revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

CR 11490 informs you that MACs and Medicare's Shared System Maintainers (SSMs) updated 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.

The Department of Health & Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014 under the Affordable Care Act.

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

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE

MLN Matters Number: MM11709

Related CR Release Date: May 22, 2020
Related CR Transmittal Number: R10150CP
Related Change Request (CR) Number: 11709
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

This article informs you of updates that the MACs and Shared System Maintainers (SSMs) will make to systems based on the 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 publications. These system updates are based on the CORE Code Combination List to be published on or about June 1, 2020. Make sure that your billing staffs are aware of these updates.

The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act of 2010.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11709.

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

MLN Matters Number: MM11718
Related CR Release Date: March 20,2020
Related CR Transmittal Number: R10006CP
Related Change Request (CR) Number: CR 11718
Effective Date: July 1, 2020
Implementation Date: July 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. CR11718 provides specific instruction for implementing the DMEPOS CBP files.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11718.