CMS Quarterly Provider Updates

May 2021

Today's Presenters

- Kim Thomas, CPC
  - Provider Outreach & Education Consultant
- Jean Roberts, RN, BSN, CPC
  - Provider Outreach & Education Consultant
- Jhadi Grace
  - Provider Outreach & Education Consultant

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Objectives

- Prepare Medicare providers to adapt to changes CMS implemented between 1/5/2021 and 4/5/2021

Today's Presentation

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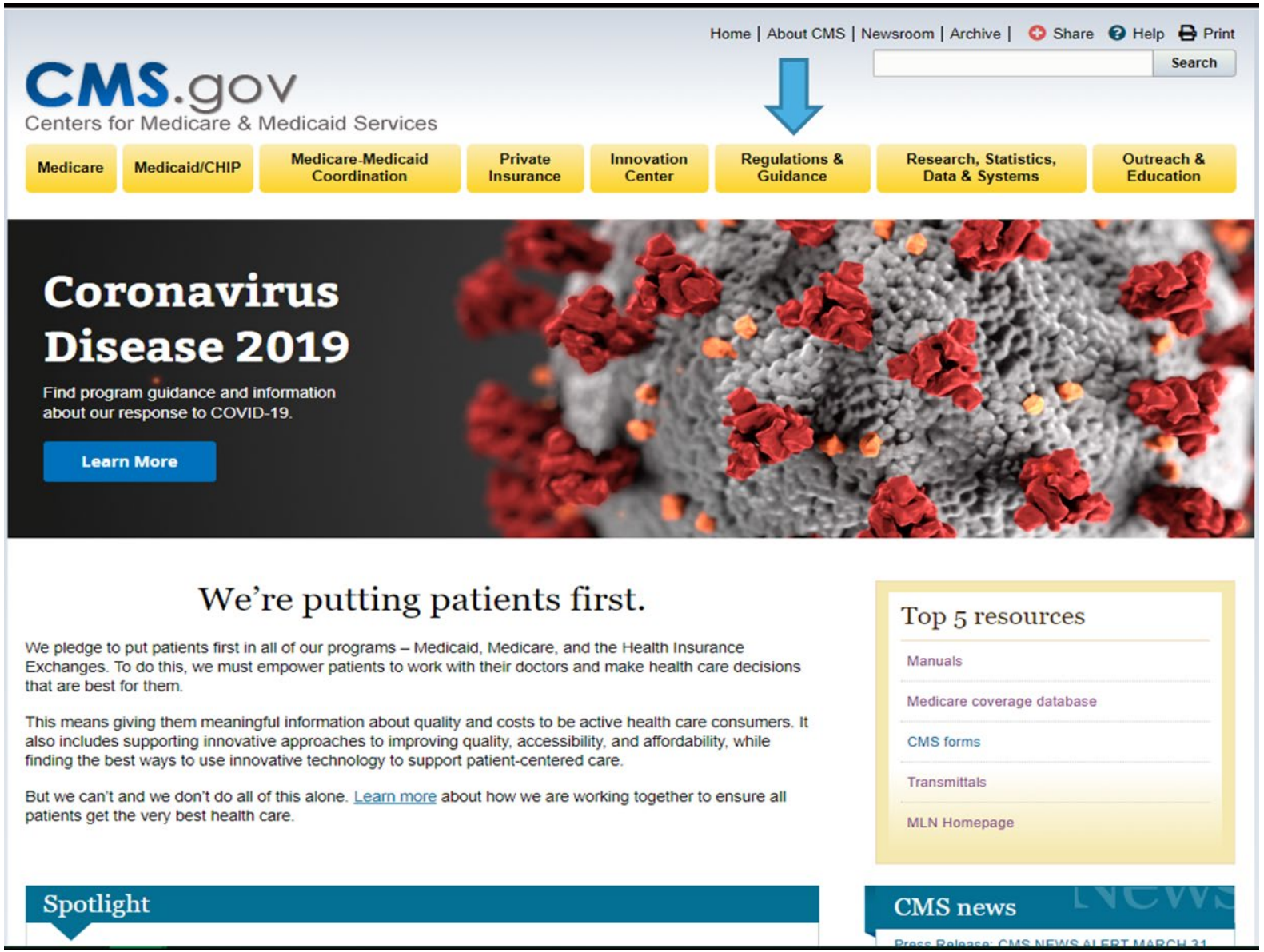
Agenda

- Background
  - Utilizing resources
- CRs and Related Resources
  - (Also Refer to Handout)
- Questions and Answers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We're putting patients first.
We pledge to put patients first in all of our programs – Medicaid, Medicare, and the Health Insurance Exchanges. To do this, we must empower patients to work with their doctors and make health care decisions that are best for them.
This means giving them meaningful information about quality and costs to be active health care consumers. It also includes supporting innovative approaches to improving quality, accessibility, and affordability, while finding the best ways to use innovative technology to support patient-centered care.
But we can't and we don't do all of this alone. Learn more about how we are working together to ensure all patients get the very best health care.
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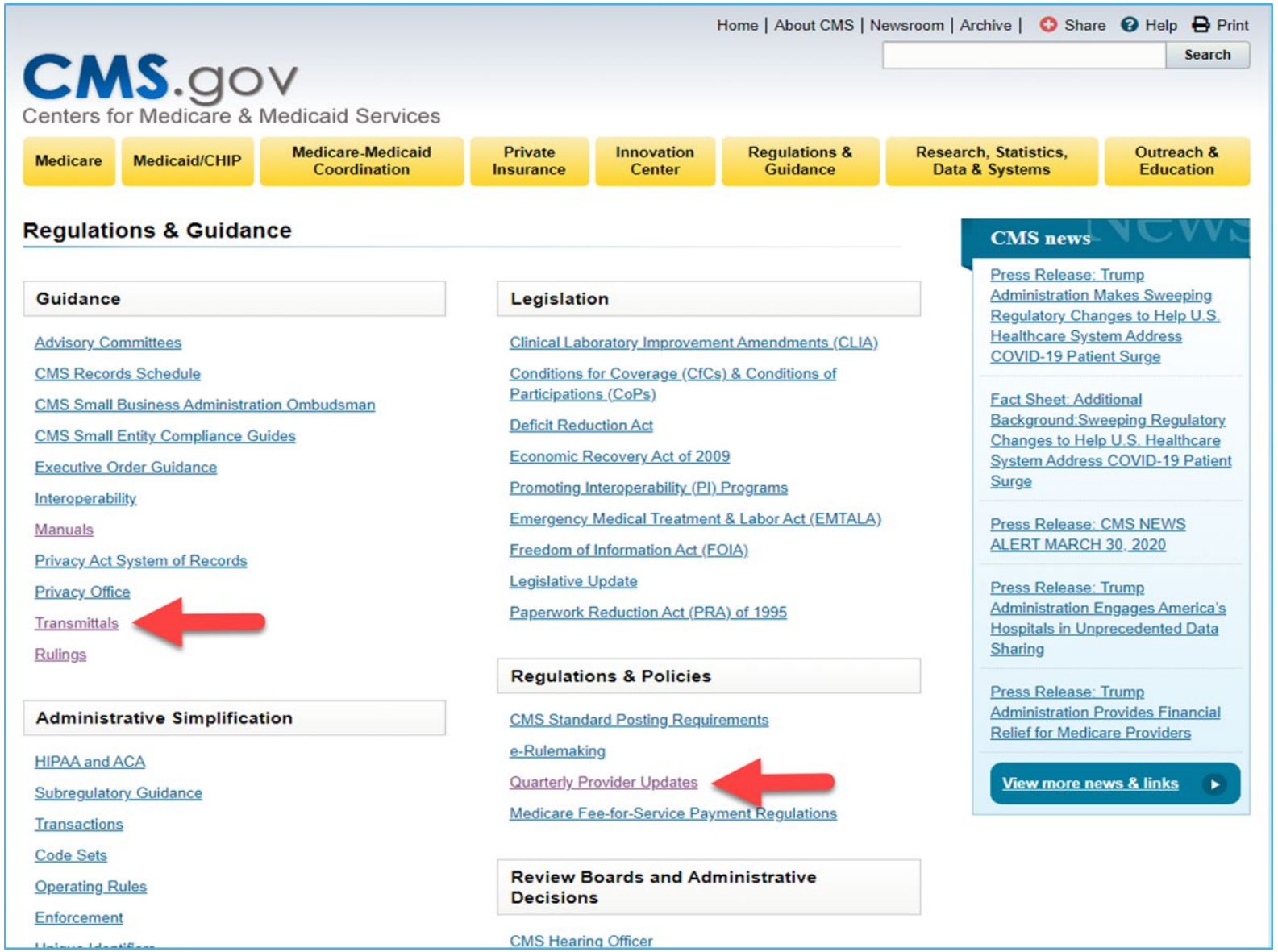
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Fact Sheet: Additional Background:Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge
Press Release: CMS NEWS ALERT MARCH 30, 2020
Press Release: Trump Administration Engages America's Hospitals in Unprecedented Data Sharing
Press Release: Trump Administration Provides Financial Relief for Medicare Providers
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Transmittal #	Issue Date	Subject	Implementation Date	CR #	MM Article #	MM Article Release Date
SE20014		Assisted Suicide Funding Restriction Act of 1997 (P.L. 105-12)			SE20014	2021-01-05
R10547CP	2020-12-31	Billing for Home Infusion Therapy Services On or After January 1, 2021	2021-01-04	11880	MM11880	
R10547BP	2020-12-31	Billing for Home Infusion Therapy Services On or After January 1, 2021	2021-01-04	11880	MM11880	
R10546CP	2020-12-31	January 2021 Update of the Ambulatory Surgical Center (ASC) Payment System	2021-01-04	12129	MM12129	2021-01-05
R10542CP	2020-12-31	2021 Annual Update to the Therapy Code List	2021-01-04	12126	MM12126	2020-12-31
R10540CP	2020-12-31	January 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.0	2021-01-04	12114	MM12114	2021-01-05

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Quarterly Provider Updates

- QPU April - June 2021
- QPU January - March 2021
- QPU October - December 2020
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- QPU October - December 2019
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- QPU January - March 2019
- QPU October - December 2018
- QPU July - September 2018
- QPU April - June 2018
- QPU January - March 2018

Quarterly Provider Updates

Welcome to the Centers for Medicare & Medicaid Services' (CMS) Quarterly Provider Update (QPU). By publishing this Update, we intend to make it easier for providers, suppliers, and the general public to understand the changes we are proposing or making in the programs we administer (for example, Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

CMS publishes this Update to inform the public about the following:

- Regulations and major policies completed or cancelled.
- New/Revised manual instructions

CMS regulations establish or modify the way CMS administers its programs. CMS' regulations may impact providers or suppliers of services or the individuals enrolled or entitled to benefits under CMS programs. Regulations that CMS plans to publish within the upcoming year can be found on OMB's Unified Agenda web site.

Archived QPU 2002 - 2012

Archived QPU 2013 - 2017

Publication Schedule

CMS generally limits the number of days it publishes regulations and notices in the "Federal Register" to the fourth Friday of each month. By limiting the number of days that it publishes regulations and notices, CMS hopes to add an element of predictability to its communications with the public and reduce the time it takes for the public to research changes. Some of our regulatory work, however, is mandated by specific statutory publication dates, and CMS will continue to comply with the statutory requirements.

Proposed Regulations

CMS publishes its regulations in the daily national "Federal Register". The "Federal Register" is available online and at many public libraries and colleges. To view regulations and notices published this quarter, refer to the Listing of Quarterly Provider Updates.

A "proposed rule" or proposed regulation announces CMS' intent to issue a new regulation or modify an existing regulation. A proposed regulation also solicits public comments during a comment period. It sets forth proposed amendments to the Code of Federal Regulations (CFR), but does not amend the CFR.

Change Requests

CR 11783

- NCD 110.24: Chimeric Antigen Receptor (CAR) T-cell Therapy
  - Implemented: 2/16/2021
  - Effective: 8/7/2019 for claims with dates of service on or after 8/7/2019
    - CMS covers autologous treatment for cancer with T-cells expressing at least one CAR when administered at healthcare facilities enrolled in the FDA Risk Evaluation and Mitigation Strategies (REMS) and meets specified FDA conditions or for other uses when the product has been FDA approved and the use is supported in one or more CMS-approved compendia.

CR 11783

- Bill Types used for CAR T-cell therapy services:
  - 011x – Inpatient Hospital
  - 012x – Inpatient Ancillary Hospital
  - 013x – Outpatient Hospital
  - 085x – Critical Access Hospital

CR 11783

- Revenue Codes
  - 0871 – Cell Collection with CPT code 0537T
  - 0872 – Specialized Biologic Processing and Storage – Prior to Transport with CPT 0538T
  - 0873 – Storage and Processing after Receipt of Cells from Manufacturer with CPT 0539T
  - 0874 – Infusion of Modified Cells with CPT 0540T
  - 0891 – Special Processed Drugs – FDA Approved Cell Therapy with HCPCS Q2041, Q2042, or C9399

CR 11783

- HCPCS Codes
  - Q2042 for Tisagenlecleucel,
  - Q2041 for Axicabtagene Ciloleucel
  - C9399 for unclassified drugs or biologicals when dose of CAR T-cell therapy exceeds code descriptor
  - 0537T collection/handling*
  - 0538T preparation for transport*
  - 0539T receipt and preparation*
  - 0540T the administration

* ***Tracking Codes Only***: Procedure represents the various steps required to collect and prepare the genetically modified T-cells, and these steps are not paid separately under the OPPS.

CR 11783

- ICD-10 Diagnosis Codes
  - C83.11-C83.19, C83.31 – C83.39, C85.11 – C85.19, C85.21 – C85.29, C85.81 – C85.89, C91.00, C91.02
- ICD-10-PCS Procedure Codes - Inpatient claims:
  - XW033C3: Introduction of Engineered Autologous Chimeric Antigen Receptor T-cell Immunotherapy into Peripheral Vein, Percutaneous Approach, New Technology Group 3
  - XW043C3: Introduction of Engineered Autologous Chimeric Antigen Receptor T-cell Immunotherapy into Central Vein, Percutaneous Approach, New Technology Group 3

CR 11783

- Additional Information on Coverage and billing:
  - Change Request 11783: NCD update & Claims Processing update
  - CMS IOM Pub. 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, Section 310.1, Routine Costs in Clinical Trials
  - CMS IOM Pub. 100-03, *National Coverage Determinations*, Chapter 1, Part 2, Section 110.24, Chimeric Antigen Receptor (CAR) T-cell therapy
  - CMS IOM Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 32, Section 400, Section 400, Chimeric Antigen Receptor (CAR) T-cell therapy

CR 11975

- Update to Vaccine Services Editing
  - Implemented: 4/5/2021
  - Effective: 4/1/2021
  - Updated to allow an inpatient SNF 21X claim that contains a “From” DOS that overlaps only the “Through” date of a vaccine (revenue code 0636 or 0771) or telehealth outpatient claim (TOB 12X containing HCPCS Q3014) for the same beneficiary
  - Updated to allow vaccines and its administration when they are the only services on a 12x TOB with the DOS is equal to the discharge date of an inpatient claim for the same provider and the service date is equal to the "From" date of another inpatient claim with condition code B4 for the same provider.

CR 11992

- Updates to SNF PDPM Claims
  - Implemented: 4/5/2021
  - Effective: 4/1/2021
  - Providers impacted: SNFs TOB 21X and hospital swing bed providers TOB 18X (subject to SNF PPS)
    - Occurrence span code 76 is used to identify days when the beneficiary is liable: Add OSC 76 to 21X/18X claim that contains both covered days and noncovered days when the noncovered days are the responsibility of the beneficiary (e.g., days submitted for noncovered level of care)

CR 11992

- Modifies existing overlap editing to correctly account for SNF interrupted stays reported at the end of a month effective on/after 10/1/2019
  - SNF interrupted stay is billed with occurrence span code 74 equal to three days or less
    - SNF CB edits do not apply to a SNF interrupted stay
  - OSC 76 “through date” plus one day is used as a new admission date for payment purposes and will pay at day one of the VPD.
    - Revenue code 0022 lines correspond to occurrence code 50 dates in line item sequence
    - Example: If there are 3 occurrence code 50 dates on the claim with dates 10/1, 10/10 and 10/25, the 10/10 occurrence code 50 date corresponds to the second 0022 line

New Claim Level Reason Code

- A SNF (21X) or SB (18X) claim has been submitted with a missing or incorrect Occurrence Code '50' entry
- A Non covered period (OSC '76') is present on the claim without a covered period (OC Code 50' entry) occurring directly after the non-covered period
- The OC '50' entry's start date must be one day after the OSC '76' thru date
- PLEASE VERIFY BILLING AND IF APPROPRIATE, CORRECT

  **ONLINE PROVIDERS: PRESS PF9 TO STORE THE CLAIM

  **OTHER PROVIDERS: RETURN TO THE MAC

- **Note:** Reason code 11992 will not assign if OSC 76 is not present or when OCS 76 “through” date is equal to “through” date of claim

CR 12023

- Home Health Manual Update to Incorporate Allowed Practitioners into Home Health Policy
  - Implemented: 1/11/2021
  - Effective: 3/1/2020
  - CARES Act amends regulations to define a NP, a CNS, and a PA as “allowed practitioners” meaning that in addition to a physician, an “allowed practitioner” may certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare HH benefit.
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7

CR 12062

- April 2021 Update to the FY 2021 IPPS
  - Implemented: 4/5/2021
  - Effective: 4/1/2021
  - Corrects calculation of the DSH payment, where the payment was not applied correctly for RRCs, including those that are also an SCH, and MDH providers with a CBSA location that is not Rural.

CR 12062

- Updates FY 2021 IPPS PPS Pricer to allow for up to 10 National Drug Codes to be passed to the IPPS PPS Pricer for payment consideration of New Technologies and emerging medical services
- Updates Pricer logic related to the 20% increase to the DRG weight applicable to COVID-19 discharges in FYs 2020 and 2021 (implemented by CARES Act) and allows Part A MAC to update impacted cost reports with the correct HSP rate payment for SCHs and MDHs
  - Applies to MDH, MDH RRC, SCH, SCH RRC, EACH, or EACH RRC for claims with discharge date on/after 1/27/2020 and on/before 3/31/2020 when diagnosis code B97.29 was reported OR the discharge date is on/after 4/1/2020 and diagnosis code U07.1 was reported
  - Impacted claims were processed prior to implementation date of updated IPPS Pricer
  - Claims for admissions on/after 9/1/2020, reporting Condition Code ZA may be excluded from the reprocessing criteria

CR 12062

- Update to correct dollar amount displayed in PPS Outlier Threshold that is used to determine the first day after the Cost Outlier threshold is reached
  - Impacts reporting of Occurrence Code 47 date and application of the beneficiary's Lifetime Reserve and/or Coinsurance Days
  - Applies to claims processed on/after 1/4/2021 and prior to the implementation of the updated IPPS Pricer, with discharges occurring on/ after 10/1/2020 through 9/30/2021

CR 12070

- Instructions to MAC on COVID-19 Emergency Declaration Blanket Waivers for Medicare-Dependent, Small Rural Hospitals and Sole Community Hospitals
  - Implemented: 3/29/2021
  - Effective: 1/26/2021
  - Effective for hospital discharges or cost-reporting periods, as applicable, occurring on or after the start of the COVID-19 emergency declaration blanket waiver period, effective 3/1/2020, through the end of the emergency declaration:

CR 12133

- April 2021 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing File
  - Implemented: 4/5/2021
  - Effective: 4/1/2021
  - ASP methodology is based on quarterly data manufacturers submit to CMS. CMS provides MACs with ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the OCE through separate instructions.
  - CMS website: Medicare Part B Drug Average Sales Price

CR 12146

- Notice of New Interest Rate for Medicare Overpayments and Underpayments -2nd Q Notification for FY 2021
  - Implemented: 1/19/2021
  - Effective: 1/19/2021
  - Department of the Treasury notified the Department of Health and Human Services that the private consumer rate has been changed to 9.625%

CR 12155

- Quarterly Update to the MPFSDB - April 2021 Update
  - Implemented: 4/5/2021
  - Effective: 1/1/2021
  - New code effective for DOS beginning 1/1/ 2021: G2211
  - Codes updates effective for DOS beginning 4/1/2021: A9592, G2020, G2172, G9868, G9869, G9870, J1427, J1554, J7321, J7333, J7401, J7402, J9037, J9349, Q2053, S1091
  - Correction of indirect practice expense, retroactive to 1/1/2021: G2082, G2083
  - Code 99417 is not valid for Medicare purposes

CR 12175

- April 2021 Update of the Hospital OPPS
  - Implemented: 4/5/2021
  - Effective: 4/1/2021
  - Revised APC assignments effective 4/1/2021:
    - CPT codes 0001A and 0011A changed from APC 1492 to APC 9397
    - CPT codes 0002A and 0012A changed from APC 1493 to APC 9398
  - Janssen/Johnson & Johnson vaccine received EUA effective 2/27/2021
    - Janssen specific coding: CPT code 91303 – drug product and 0031A – administration

CR 12175

- Effective 2/9/2021, 2 new HCPCS codes for bamlanivimab and etesevimab: M0245 (drug) and Q0245 (administration & post administration monitoring)
- Medicare does not make separate payment when a drug/vaccine is provided to you for free

- CMS website COVID-19 and Monoclonal Antibodies features payment and effective dates for the COVID-19 vaccines and their administration during the PHE
- Additional information on Monoclonal Antibody COVID-19 Infusion

CR 12175

- New effective 4/1/2021
  - Six PLA codes (CPT codes 0242U through 0247U),– refer to Table 4 of CR 12175 for descriptors and SIs
  - C9776 describes the application of intraoperative near-infrared fluorescence imaging using indocyanine green to visualize the major extrahepatic ducts associated with laparoscopy cholecystectomy
  - C9777 describes the technology associated with esophageal mucosal integrity testing by electrical impedance

CR 12175

- Effective 12/31/2020, deleted HCPCS codes G2061, G2062, and G2063 and replaced these codes with 98970, 98971, and 98972, respectively
  - 98970, 98971, and 98972: April 2021 I/OCE reflects change, effective 1/1/2021 and assigned SI A
- Effective 1/1/2021: G2010, G2012, and G2211 replaced with HCPCS codes G2250 and G2251 for certain non-physician practitioners, including rehabilitation therapists; April I/OCE corrects status indicator for G2250 and G2251 to SI B
- April I/OCE also correct SI of G221 to SI BB

CR 12175

- Additional coding updates are included in the tables attached to CR 12175
- April 2021 OPPS Addendum B (OPPS HCPS codes & status indicators are available in OPPS Addendum D1 of the CY 2021 OPPS/ASC final rule)

CR 12178

- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
  - Implemented: 4/5/2021
  - Effective: 4/1/2021
  - Next CLFS data reporting period for CDLTs is *delayed*
  - New codes, effective 4/1/2021: 0242U – 0247U, 0098U - 0100U

CR 12185

- Update to RHC Payment Limits
  - Implemented: 4/5/2021
  - Effective: 4/1/2021
  - Update to exclude temporarily added surge capacity beds due to the PHE for the COVID-19 pandemic from a hospital's bed count for purposes of determining whether an RHC that is provider-based to that hospital is exempt from the national payment limit per visit

CR 12185

- Provider based RHCs that meet the definition in Section 1881(f)(3)(B), will have a payment limit per visit established at an amount equal to the greater of: payment per visit amount applicable to the PB RHC for services furnished in 2020 , increased by the percentage increase in CY 2021 MEI of 1.4%, or the payment limit per visit applicable to RHCs (see next slide)
  - In subsequent years (after 2021), the PB RHC's payment limit per visit is the greater of: Payment per visit amount applicable to each PB RHC for services furnished in the previous year, increased by the percentage increase in MEI applicable to primary care services furnished as of the first day of that year, or payment limit per visit applicable to each year for RHCs (see next slide)

CR 12185

- RHCs payment limit per visit will increase over 8 years beginning 4/1/2021 (except those with an exception to the payment limit). The RHC payment limit per visit over an 8-year period is as follows:
  - In 2021, after March 31, at $100 per visit
  - In 2022, at $113 per visit
  - In 2023, at $126 per visit
  - In 2024, at $139 per visit
  - In 2025, at $152 per visit
  - In 2026, at $165 per visit
  - In 2027, at $178 per visit
  - In 2028, at $190 per visit

CR 12187

- April 2021 I/OCE Specifications Version 22.1
  - Implemented: 4/5/2021
  - Effective: 4/1/2021
  - I/OCE quarterly release specifications files are available on the CMS website
  - Updates program logic for FQHC claims (77x) for new opioid use disorder (OUD) treatment demonstration HCPCS code G2172
  - Revises effective date for HCPCS codes:
    - M0239, Q0239 (effective date 11/9/2020)
    - 0001A, 0002A, 91300 (effective date 12/11/2020)
    - 0011A, 0012A, 91301 (effective date 12/18/2020)

CR 12187

APC, HCPCS, SI Updates (not full list)

APC	HCPCS	Eff Date	Description	Status Indicator	Payment
09397	0001A; 0011A	4/1/2021	COVID-19 Vaccine Administration Dose 1 of 2	S	$16.94
09398	0002A; 0012A; 0031A	4/1/2021	COVID-19 Vaccine Administration Dose 2 of 2 or Single Dose Product	S	$28.39
09406	Q5122	4/1/2021	Inj, nyvepria	K	$0
09406	Q5122	4/1/2021	Inj, nyvepria	G	$0
09407	C9074	4/1/2021	Injection, lumasiran	G	$0

Reminder: Deductible/Coinsurance do not apply to COVID-19 Vaccine administration

CR 12187

Coinsurance And Deductible Waiver Eligible Additions

Reason Key: A=Added To List, N=New Code

HCPCS	Eff Date	Description	R*
98966	2020-01-01	Hc pro phone call 5-10 min	A
98967	2020-01-01	Hc pro phone call 11-20 min	A
98968	2020-01-01	Hc pro phone call 21-30 min	A
G2250	2021-01-01	Remot img sub by pt, non e/m	A
G2251	2021-01-01	Brief chkin, 5-10, non-e/m	A
G2252	2021-01-01	Brief chkin by md/qhp, 11-20	A

CR 12187

Added to Skin Substitute High Cos Product

Reason Key: A=Added To List, N=New Code

HCPCS	Eff Date	Description	R*
Q4167	2021-01-01	Truskin, per sq centimeter	A
Q4182	2021-01-01	Transcyte, per sq centimeter	A
Q4188	2021-01-01	Amnioarmor 1 sq cm	A
Q4190	2021-01-01	Artacent ac 1 sq cm	A
Q4193	2021-01-01	Coll-e-derm 1 sq cm	A
Q4198	2021-01-01	Genesis amnio membrane 1sqcm	A
Q4200	2021-01-01	Skin te 1 sq cm	A
Q4209	2021-01-01	Surgraft per sq cm	A
Q4211	2021-01-01	Amnion bio or axobio sq cm	A
Q4219	2021-01-01	Surgigraft dual per sq cm	A

CR 12188

- Implementation of Changes in the ESRD PPS and Payment for Dialysis Furnished for AKI in ESRD Facilities for CY 2021
  - Implemented: 4/5/2021
  - Effective: 1/1/2021
  - CY 2021 ESRD PPS base rate is $253.13 per treatment
  - CY 2021 AKI Dialysis Payment Rate for Renal Dialysis Services is $253.13 per treatment

CR 12188

- Outlier Policy:
  - Adjusted average outlier service MAP amount per treatment is $50.92 for adult patient or $30.88 for pediatric patients
  - Changes to list of outlier services:
    - Renal dialysis drugs that are oral equivalents to injectable drugs are based on the most recent prices obtained from the Medicare Prescription Drug Plan Finder and are updated to reflect the most recent mean unit cost; items and services eligible for outlier payment are removed from list of outlier service
      - Oral and Other Equivalent Forms of Injectable Drugs table – see Attachment A of CR 12188

CR 12188

- Mean dispensing fee of NDCs qualifying for outlier consideration is revised to $0.58 per NDC, per month for claims with dates of service on or after 1/1/2021.
  - (See the related tables in Attachment A of CR 12188.)
- Consolidated Billing Requirements: The current version of the CB requirements are available on the CMS website

CR 12212

- April 2021 Quarterly Update to HCPCS Codes Used for SNF CB Enforcement
  - Implemented: 4/5/2021
  - Effective: 4/1/2021
  - To assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB
  - SNF CB website and files for institutional and professional billing: 2021 Annual CB files (zip file) and General Explanation of the Major Categories for SNF CB

CR 12212

- Revision made to annual files
  - 2017 & 2019 – effective 1/1/2020 delete 0019T & 64550 from file 4
  - 2020 – effective 1/1/2020 delete 95831-95834, G8987-G8999, G9158-G9176, G9186 from file 4
    - Add to file 1: Bamlanivimab – Q0239, M0239 (effective 11/9/2020); Casirivimab + Imdevimab – Q0243, M0243 (effective 11/21/2020); Pfizer – 91300, 0001A, 0002A (effective 12/11/2020); Moderna – 91301, 0011A, 0012A (effective 12/18/2020)
    - Add to file 1: 98966 (Hc pro phone call 5-10 min); 98967 (Hc pro phone call 11-20 min); and 98968 (Hc pro phone call 21-30 min)
  - 2021 – effective 1/1/2020 delete 95831 - 95834, G8978-G8999, G9158-G9176, G9186 from file 4; add COVID-19 vaccines (Q0201 - Q0250) and administration (M0201 - M0250) to file 1

SE21001

- Review of Hospital Compliance with Medicare's Transfer Policy with the Resumption of Home Health Services & Other Information on Patient Discharge Status Codes
  - Issued: 2/22/2021
  - OIG reviews identified Medicare overpayments for hospitals that did not comply with Medicare's post-acute transfer policy
  - To assure proper payment under the MS-DRG payment system, inpatient hospitals must code correctly - including accurate discharge/transfer status of patients to accurately reflect the patient's level of post-discharge care

SE21001

- Providers must code the discharge bill based on the discharge plan; however, if the patient receives post-acute care that changes the discharge/transfer status then the hospital must submit claim adjustment
- SE21001 includes additional information on: Discharge, Acute care transfer, and post-acute care transfer are defined along with applicable coding

- OIG report: August 2020 Report No. A-04-18-04067
- Medicare claim adjustment criteria: CMS IOM Pub, 100-04, *Medicare Claims Processing Manual*
  - Chapter 1, Section 130.1.1
  - Chapter 34

SE21002

- Billing for Services when Medicare is a Secondary Payer
  - Issued: 2/23/2021
  - Physicians, hospitals, SNFs, suppliers and other providers who bill MACs or DME MACs for services provided to Medicare beneficiaries
  - Do not deny treatment, entry to a SNF or hospital, or services based on an open or closed L, NF or WC MSP record on the beneficiary's Medicare file or if a claim was inappropriately denied
  - Providers must continue to see or provide services

SE21002

- When another insurance is primary, bill that insurance first
- Bill the other insurer as primary If services relate to an open MSP accident or injury incident
- Medicare may inappropriately deny a claim when the diagnosis codes on the claim and the MSP record are the same, or within the same family
  - Appeal the inappropriately denied claim with your MAC
    - Provider must include an explanation or a reason code to justify the services aren't related to the accident or injury on record

SE21002

- Reminders:
  - Collect health insurance information at each visit
  - Check Medicare eligibility to confirm insurance and identify any accident/injury diagnosis codes for MSP periods
  - Identify primary payer before billing
  - Bill accident-related services and non-accident related services separately
    - Always use specific diagnosis codes related to the accident or injury

SE21002

- CMS MLN Booklet (ICN MLN006903): Medicare Secondary Payer
- CMS MLN Fat Sheet (ICN MLN8816413): Checking Medicare Eligibility
- CMS IOM Pub. 100-05, *Medicare Secondary Payer (MSP) Manual,* Chapter 3, MSP Provider, Physician, and Other Supplier Billing Requirements

SE21003

- New Provider Enrollment Administrative Action Authorities
  - Issued: 3/24/2021
  - CMS issued “Program Integrity Enhancements to the Provider Enrollment Process,” (CMS-6058-FC) Final Rule on 9/10/2019 to stop fraud before it happens by keeping problematic providers and suppliers out of our Federal health insurance programs
    - Created several new revocation and denial authorities, as well as other supporting authorities, to strengthen CMS’ efforts to stop fraud, waste, and abuse

SE21003

- CMS will issue affiliation disclosure requests on a discretionary basis to request that a provider or supplier disclose all applicable affiliations if we become aware that the provider likely has at least one potentially problematic affiliation
- CMS will begin requesting affiliation disclosures after the Form CMS-855 applications are revised to include affiliation disclosure sections
  - Includes online enrolment applications in the PECOS
- New regulatory authority for reenrollment bar expansion and reapplication bar

SE21004

- Repayment of COVID-19 Accelerated and Advance Payments Began on 3/30/2021
  - Issued: 4/1/2021
  - Attention all Medicare providers and suppliers who requested and received CAAPs from CMS due to the COVID-19 PHE): CMS began recovering those payments as early as 3/30/2021, depending upon the one year anniversary of when you received your first payment

SE21004

- Repayment of the CAAP from Medicare payments continues for 11 months at rate of 25%
- When initial 11 month period ends, recoupment continues at 50% for the next six months
- Once the six month recoupment period ends, NGS will issue a demand letter for full repayment of any remaining balance of the CAAP.
  - If full payment is not made within 30 days, interest will accrue at the rate of 4% (based on date of demand letter)
  - Interest will be assessed for each full 30-day period that provider fails to repay the balance

SE21004

- NGS article: Accelerated and Advance Payment Program
  - Includes additional information and FAQs
- NGS You Tube video: Accelerated/Advance Payments During the Public Health Emergency
- NGS article "Checking the Status of Your Accelerated of Advance Overpayment"

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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