Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

July 2020

In this issue

Strapping – retired Part A and Part B LCD/Billing and Coding Article

LCD/Article ID number: L34023/A57129 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) and billing and coding article for strapping, it was determined that they are no longer required and therefore, are being retired.

Effective date

This LCD and billing and coding article retirement is effective for services rendered **on or after July 23, 2020**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Contents

The *Medicare B Connection* is published monthly by First Coast Service Options Inc.'s Provider Outreach & Education division to provide timely and useful information to Medicare Part B providers.

Articles included in the *Medicare B Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

About the Medicare B Connection

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare *provider education website*. In some cases, additional unscheduled special issues may be posted.

Who receives the *Connection*

Anyone may view, print, or download the *Connection* from our provider education website(s). Providers who cannot obtain the *Connection* from the internet are required to register with us to receive a complimentary hardcopy.

Distribution of the *Connection* in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the *Connection* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare provider enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.
- In addition to the above, other sections include:
- **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

The *Medicare B Connection* represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our *"time limit" calculators on our Appeals of claim decisions page*. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Medicare Part B advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). *Section 50 of the Medicare Claims Processing Manual*.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found *here*.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (waiver of liability statement on file).

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the applicable contact section located at the end of this publication for the address in which to send written appeals requests.

This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our *LCDs/Medical Coverage webpage* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the *First Coast eNews mailing list*. Simply enter your email address and select the subscription option that best meets your needs.

More information

For more information, or, if you do not have internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? *First Coast's LCD lookup* helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's web team.

Revised LCDs/Articles

Wound care – revision to the Part A and Part B LCD

LCD ID number: L37166 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on the retirement of the local coverage determination (LCD) and billing and coding article for strapping (L34023/ A57129), the wound care LCD (L37166) was revised to remove all language referencing the strapping LCD.

Effective date

This LCD revision is effective for services rendered **on or after July 23, 2020**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Infliximab – revision to the Part A and Part B billing and coding article

Article ID number: A57653 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on the July 2020 Quarterly Update, the billing and coding article for infliximab was revised to add Healthcare Common Procedure Coding System (HCPCS) code Q5121 to the "CPT®/HCPCS Codes/Group 1 Paragraph:/Group 1 Codes:" and "ICD-10 Codes that Support Medical Necessity/ Group 1 Paragraph:" sections of the billing and coding article.

Effective date

This billing and coding article revision is effective for services rendered **on or after July 1, 2020**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Pegfilgrastim – revision to the Part A and Part B billing and coding article

Article ID number: A57725 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on the July 2020 Quarterly Update, the "CPT®/ HCPCS Codes/Group 1 Paragraph:/Group 1 Codes:" and "ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:" sections of the billing and coding article for pegfilgrastim were revised to remove Healthcare Common Procedure Coding System (HCPCS) codes C9058 and J3590 and to add HCPCS code Q5120.

Effective date

The billing and coding article revision to remove HCPCS code C9058 is effective for services rendered **on or after July 1, 2020**. However, prior to its deletion the effective date of this code has been changed to **November 15, 2019**.

The billing and coding article revision to add HCPCS code Q5120 and remove HCPCS code J3590 is effective for claims processed **on or after July 6, 2020**, for services rendered **on or after November 15, 2019** for Part B and for Part A the revision to add HCPCS code Q5120 is effective for services rendered **on or after July 1, 2020**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Trastuzumab - trastuzumab biologics – revision to the Part A and Part B billing and coding article

Article ID number: A56660 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on the July 2020 Quarterly Update, the "CPT®/HCPCS Codes/Group 1 Paragraph:/Part A and Part B/Group 1 Codes:" sections of the billing and coding article for trastuzumab - trastuzumab biologics were revised to remove Healthcare Common Procedure Coding System (HCPCS) code C9399 and add HCPCS codes J9358, Q5113 and Q5116. Also, the "CPT®/HCPCS Codes/Group 2 Paragraph:/Part B/Group 2 Codes:" sections of the billing and coding article were revised to remove HCPCS code J9999, Q5112, Q5113 and Q5116 (HCPCS codes Q5112, Q5113 and Q5116 are now listed under Part A and Part B/Group 1 Codes:). In addition, the "ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:" section of the billing and coding article was revised to remove HCPCS codes C9399 and J9999 and add HCPCS code J9358. The following revision is not related to the July 2020 Quarterly Update: HCPCS code Q5114 was also removed from the "CPT®/HCPCS Codes/Group 2 Codes:" section of the billing and coding article as it is appropriately listed in the CPT®/HCPCS Codes/Group 1 Codes:" section of the billing and coding article.

Effective date

The revision related to removing HCPCS codes C9399 and J9999 and adding HCPCS code J9358 is effective for services rendered **on or after July 1, 2020**.

The revision related to HCPCS code Q5113 is effective for claims processed **on or after July 6, 2020**, for services rendered **on or after March 16, 2020**.

The revision related to HCPCS code Q5112 is effective for claims processed **on or after July 30, 2020**, for services rendered **April 15, 2020-September 30, 2020**.

The revision related to HCPCS code Q5116 is effective for claims processed **on or after July 6, 2020**, for services rendered **on or after February 23, 2020**.

The revision related to HCPCS code Q5114 is effective for claims processed **on or after January 6, 2020**, for services rendered **on or after November 29, 2019**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Hemophilia clotting factors – revision to the Part A and Part B billing and coding article

Article ID number: A56482 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on the July 2020 Quarterly Update, Healthcare Common Procedure Coding System (HCPCS) code J7204 (Injection, factor viii, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei, per iu), was added to the "CPT®/HCPCS Codes/Group 6 Codes:" and "ICD-10 Codes that Support Medical Necessity/Group 6 Paragraph:" sections of the billing and coding article for hemophilia clotting factors.

Effective date

This billing and coding article revision is effective for services rendered **on or after July 1, 2020**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Allergy testing – revision to Part A and Part B billing and coding article

Article ID number: A57531 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on the July 2020 Quarterly Update, Current Procedural Terminology (CPT®) code 0178U was added to the "CPT®/HCPCS Codes/Group 1 Codes:" and "ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:" sections of the billing and coding article for allergy testing. In addition, the descriptor for CPT® code 0165U was changed.

Effective date

This billing and coding article revision is effective for services rendered **on or after July 1, 2020**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Viscosupplementation therapy for knee – revision to Part A and Part B billing and coding article

Article ID number: A57256 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on the July 2020 Quarterly Update, the billing and coding article for viscosupplementation therapy for knee was revised to add Healthcare Common Procedure Coding System (HCPCS) code J7333 to the "Coding Guidelines", "CPT®/HCPCS Codes/ Group 1 Codes:/Group 2 Codes:" and "ICD-10 Codes that Support Medical Necessity/ Group 1 Paragraph:/Group 2 Paragraph:" sections of this billing and coding article. Also, HCPCS code J7321 had a descriptor change.

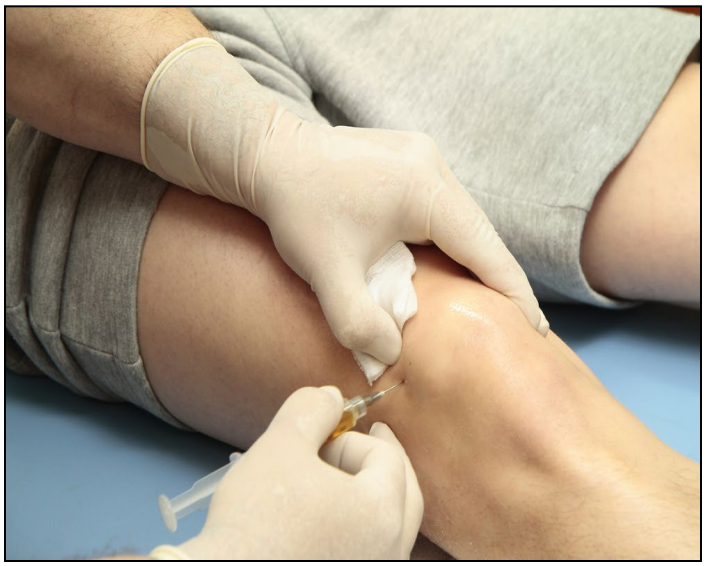
In addition, based on change request (CR) 11068/ CR 11099 and review of the billing and coding article, HCPCS code J7329 was added to the "CPT®/HCPCS Codes/ Group 1 Codes:" and "ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:" sections of this billing and coding article.

Effective date

The billing and coding article revision related to the July 2020 Quarterly Update is effective for services rendered **on or after July 1, 2020.**

The billing and coding article revision related to HCPCS code J7329 is effective for claims processed **on or after June 22, 2020**, for services rendered on **or after January 1, 2019**.

LCDs are available through the CMS Medicare coverage



database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Endovenous stenting – revision to Part A and Part B billing and coding article

Article ID number: A56644 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on review of the Billing and Coding Article, the information in the billing and coding article was reformatted.

Effective date

This revision is effective for services rendered **on or after June 25, 2020**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Independent diagnostic testing facility (IDTF) – revision to the Part B billing and coding article

Article ID number: A57807 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on the July 2020 Quarterly Update, Current Procedural Terminology (CPT®) codes 0604T, 0605T, 0606T, 0607T, 0608T, 0609T, 0610T, 0611T, 0612T, and 0615T were added to the "Credentialing Matrix" table section of this billing and coding article.

Effective date

This billing and coding article revision is effective for services rendered **on or after July 1, 2020**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Nerve conduction studies and electromyography – revision to the Part A and Part B Billing and Coding Article

Article ID number: A57123 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on further review, the "ICD-10 Codes that Support Medical Necessity/Group 1 Codes:" section of the nerve conduction studies and electromyography billing and coding article was revised to include ICD-10-CM diagnosis code range M60.80-M60.9, which was omitted in error during the process of moving the ICD-10-CM diagnosis codes from the local coverage determination (LCD) to the billing and coding article. Also, Current Procedural Terminology (CPT®) code 95999 and Healthcare Common Procedure Coding System (HCPCS) code G0255 have been removed from "ICD-10 Codes that Support Medical Necessity/ Group 1 Paragraph:" section of the billing and coding article as they were added in error during the process of moving the CPT®/HCPCS codes from the LCD to the billing and coding article.

Effective date

This billing and coding article revision is effective for services rendered **on or after October 3, 2018**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and coding article for an LCD may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Upcoming provider outreach and educational events

Medicare secondary payer: Billing MSP claims (B)

Date: Wednesday, August 26
Time: 10 - 11:30 a.m. ET
Type of Event: Webcast

View our complete calendar of events

Note: Unless otherwise indicated, designated times for educational events are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at *First Coast University*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Create User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our *website* for details and newly scheduled educational events (teleconferences, webcasts, etc.).

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

CMS MLN Connects®

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects®* is an official *Medicare Learning Network®* (*MLN*) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the *MLN Connects®* to its membership as appropriate.

MLN Connects® for Thursday, June 25, 2020

MLN Connects® for Thursday, June 25, 2020

View this edition as a PDF

News

- Trump Administration Issues Call to Action Based on New Data Detailing COVID-19 Impacts on Medicare Beneficiaries
- Hospital Outpatient Departments: Prior Authorization Begins July 1
- IRF Provider Preview Reports: Review Your Data by July 18
- LTCH Provider Preview Reports: Review Your Data by July 18
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

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

Events

- Personal Protective Equipment Strategies for COVID Care Webcast — June 25
- Medicare Part A Cost Report: New Online Status Tracking Feature Call — July 9

Publications

- Clinical Laboratory Fee Schedule Annual Payment Determination Process

MLN Connects® – Special Edition – Friday, June 26, 2020

COVID-19: SNF Benefit Period Waiver, HHAs Proposed Rule, Ending Nursing Home Blanket Waiver

- *COVID-19: SNF Benefit Period Waiver*
- *HHAs: Proposed Payment and Policy Changes and Home Infusion Therapy Benefit for CY 2021*
- *CMS Announces Plans to End the Blanket Waiver Requiring Nursing Homes to Submit Staffing Data*

COVID-19: SNF Benefit Period Waiver

Disruptions during a Public Health Emergency can affect the Skilled Nursing Facility (SNF) benefit:

- Prevent a beneficiary from having the Qualifying Hospital Stay (QHS)
- Disrupt the process of ending the beneficiary's current benefit period and renewing their benefits

Emergency waivers of QHS and benefit period requirements under §1812(f) of the Social Security Act help restore SNF coverage that beneficiaries affected by the emergency would be entitled to under normal circumstances.

Learn more about the waiver and how to bill in *MLN Matters Article SE20011*.

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

On June 25, CMS issued a proposed rule [CMS-1730-P] for FY 2021 that updates the Medicare payment rates for Home Health Agencies (HHAs). This proposed rule also includes a proposal to make permanent the regulatory changes related to telecommunications technologies in providing care under the Medicare home health benefit beyond the expiration of the Public Health Emergency for the COVID-19 pandemic.

For More Information

- *Fact Sheet*
- *Proposed Rule*

CMS Announces Plans to End the Blanket Waiver Requiring Nursing Homes to Submit Staffing Data

On June 25, CMS announced plans to end the emergency blanket waiver requiring all nursing homes to resume submitting staffing data through the Payroll-Based Journal (PBJ) system by August 14, 2020. The PBJ system allows CMS to collect nursing home staffing information which impacts the quality of care residents receive. The blanket waiver was intended to temporarily allow the agency to concentrate efforts on combating COVID-19 and reduce

See **MLN SE**, page 12

MLN Connects® for Thursday, July 2, 2020

MLN Connects® for Thursday, July 2, 2020

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News

- CMS Proposes to Expand Coverage Policy for Transcatheter Edge-to-Edge Repair for Patients with Mitral Valve Regurgitation
- Physician Compare Preview Period Open through August 20
- ABN Form Renewal
- Medicare Enrollment Application Fee Refunds through EFT

Claims, Pricers & Codes

- SNF Benefit Waiver Period: Billing Update

Events

- Nursing Home Training Series Webcasts — July 2, 9, and 16
- Medicare Part A Cost Report: New Online Status Tracking Feature Call — July 9

MLN Matters® Articles

- July 2020 Update of the Ambulatory Surgical Center (ASC) Payment System
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.3, Effective October 1, 2020
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – July 2020 Update — Revised
- National Coverage Determination (NCD) 160.18 Vagus Nerve Stimulation (VNS) — Revised
- Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer — Revised

MLN SE

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administrative burden on nursing homes so they could focus on patient health and safety during this Public Health Emergency.

The memorandum also provides updates related to staffing and quality measures used on the Nursing Home Compare website and the Five Star Rating System.

To view the memorandum to states and nursing home stakeholders, visit: *https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/changes-staffing-information-and-quality-measures-posted-nursing-home-compare-website-and-five-star*.

Medicare Learning Network®

The *Medicare Learning Network®* (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *CMS.gov*.

MLN Connects® – Special Edition – Monday, July 6, 2020

ESRD PPS CY 2021 Proposed Rule; COVID-19: New and Expanded Flexibilities for RHCs & FQHCs

- *ESRD PPS CY 2021 Proposed Rule*
- *COVID-19: New and Expanded Flexibilities for RHCs & FQHCs during the Public Health Emergency*

ESRD PPS CY 2021 Proposed Rule

On July 6, CMS issued a proposed rule that proposes to update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2021. This rule also proposes updates to the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI and proposes changes to the ESRD Quality Incentive Program (QIP).

In addition to the annual technical updates for the ESRD PPS, the proposed rule proposes the following:

- An addition to the ESRD PPS base rate to include calcimimetics in the ESRD PPS bundled payment
- Changes to the eligibility criteria and determination process for the Transitional add-on Payment adjustment for New and Innovative Equipment and Supplies (TPNIES)
- Expansion of the TPNIES to include new and innovative capital-related assets that are home dialysis machines
- A change to the low-volume adjustment eligibility criteria and attestation requirement to account for the COVID-19 public health emergency
- An update to the ESRD PPS wage index to adopt the new Office of Management and Budget delineations with a transition period
- Information received from two manufacturers whose products, a dialyzer and a cartridge for a home dialysis machine, are being considered for TPNIES in CY 2021

Additionally, the proposed rule proposes the following updates to the ESRD QIP:

- Scoring methodology changes to the ultrafiltration rate reporting measure
- Updates to the National Healthcare Safety Network validation study

The proposed CY 2021 ESRD PPS base rate is $255.59, an increase of $16.26 to the current base rate of $239.33. This proposed amount reflects the application of the proposed wage index budget-neutrality adjustment factor (.998652), the proposed addition to the base rate of $12.06 to include calcimimetics, and a proposed productivity-adjusted market basket increase as required by section 1881(b)(14)(F)(i)(I) of the Act (1.8 percent), equaling $255.59 (($239.33 x .998652) + $12.06) x 1.018 = $255.59).

The proposed rule also includes:

- Annual update to the wage index
- Update to the outlier policy
- Low-volume eligibility criteria and attestation requirement
- Impact analysis

For More Information:

- *Proposed Rule*
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (issued July 6).

COVID-19: New and Expanded Flexibilities for RHCs & FQHCs during the Public Health Emergency

On July 6, CMS updated MLN Matters Article *SE20016* to clarify how Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can apply the Cost Sharing (CS) modifier to preventive services furnished via telehealth. This update includes:

- Additional claim examples
- New section on the RHC Productivity Standard

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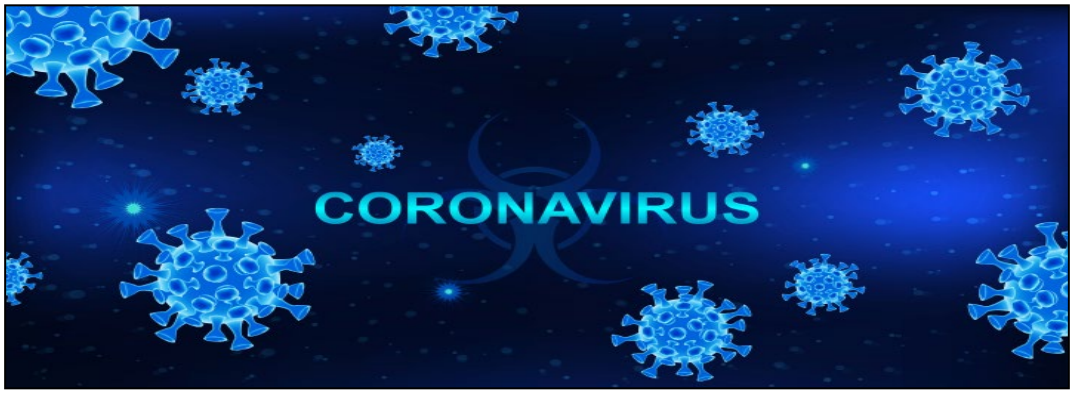

MLN Connects® for Thursday, July 9, 2020

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- Open Payments: Program Year 2019 Data
- LTCH Provider Preview Reports: Review Your Data by July 18
- IRF Provider Preview Reports: Review Your Data by July 21
- Reduce Provider Burden: Participate in Medical Documentation Interoperability Pilot
- COVID-19: Alternate Care Site Toolkit, Third Edition

Claims, Pricers & Codes

- ICD-10-CM Diagnosis Codes: FY 2021
- Teaching Physicians and Residents: Expansion of CPT Codes that May Be Billed with the GE Modifier

Events

- Nursing Home Training Series Webcasts — July 9 and 16

MLN Matters® Articles

- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
- Revising Chapters 3 and 5 of Publication (Pub.) 100-08, to Reflect the Recent Final Rule CMS-1713-F
- New Point of Origin Code for Transfer from a Designated Disaster Alternate Care Site — Revised

Publications

- Hospice Quality Reporting Program: COVID-19 PHE

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- CMS Directs Additional Resources to Nursing Homes in COVID-19 Hotspot Areas
- Five Things About Nursing Homes During COVID-19
- PEPPER for Short-term Acute Care Hospitals
- Lower Extremity Joint Replacement: Comparative Billing Report

Events

- Nursing Home Training Series Webcasts: New Topic for July 16
- COVID-19: Lessons from the Front Lines Call — July 17

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2020
- Influenza Vaccine Payment Allowances - Annual Update for 2020-2021 Season
- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2021
- October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2020 Update
- July 2020 Update of the Ambulatory Surgical Center (ASC) Payment System — Revised
- July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised
- Claim Status Category Codes and Claim Status Codes Update — Rescinded

MLN Connects® – Special Edition – Friday, July 17, 2020

COVID-19: Nursing Home Testing, SNF Benefit Period Waiver

MLN Matters Special Edition Article SE20011 *Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)* is updated. Learn about:

- Updated Centers for Disease Control and Prevention guidelines for testing nursing home residents and patients
- Update on applying the Skilled Nursing Facility (SNF) benefit period waiver

Phone numbers

Provider Contact Center
866-454-9007
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Addresses

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Medicare Part B Claims
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Jacksonville, FL 32231-0019

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P.O. Box 2360
Jacksonville, FL 32231-0018

Redetermination of overpayments
Overpayment Redetermination, Review Request
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Jacksonville, FL 32232-5248

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Websites

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First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor

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Beneficiaries
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