Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

April 2020

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Hotline

First Coast Service Options (First Coast) has established a hotline at **1-855-247-8428** to help healthcare providers in Florida, Puerto Rico, and the U.S. Virgin Islands that have been impacted by COVID-19. The hotline representatives are available **8:30 a.m.-4 p.m. ET** to assist you with initiating temporary Medicare billing privileges and address any questions you may have regarding provider enrollment flexibilities afforded by the COVID-19 waivers. This is part of the agency's ongoing efforts to provide immediate relief to our impacted providers and beneficiaries.

If you're calling to initiate temporary billing privileges, you will receive the approval or rejection decision during the call, followed by a decision letter. Please ensure you have all necessary information available at the time of the call.

Group member

- Social Security number (SSN)
- First/Last Name/Middle Initial
- Date of birth (DOB)
- Type 1 national provider identifier (NPI)
- State where you are physically located and providing services
- Specialty
- Medical school and graduation date
- State license information
- Correspondence address
- Organization provider transaction access number (PTAN) where the provider will be reassigning benefits or:
- Organization legal business name

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

Articles included in the *Medicare A 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.

COVID-19 from page 1

- Organization tax identification (ID) number
- Organization NPI

Physician assistant (PA)

- SSN
- First/Last Name/Middle Initial
- DOB
- Type 1 NPI
- State where you are physically located and providing services
- Medical school and graduation date
- State license information
- Correspondence Address
- Organization PTAN where the PA will be establishing employment or:
- Organization legal business name
- Organization tax ID Number
- Organization NPI

Sole proprietor

- SSN
- First/Last Name/Middle Initial
- DOB
- Type 1 NPI
- State where you are physically located and providing services
- Specialty
- Medical school and graduation date
- State license information
- Correspondence address
- Practice location and special payments address
- Electronic funds transfer (EFT) information

Organization

- Tax ID number
- Legal business name
- Type 2 NPI
- State where you are physically located and providing the services
- Correspondence address
- Practice location and special payments address
- Owner and managing employee
- EFT information

Additional waivers

For a period of 90 days, First Coast has implemented provider enrollment relief for providers in Florida, Puerto Rico, and the U.S. Virgin Islands. During this period, we will:

- Refrain from mailing any revalidation letters, including subsequent revalidation letters (e.g., payment hold and deactivation letters due to non-response to revalidation or revalidation development).
- Refrain from placing providers/suppliers on payment hold and deactivating providers/suppliers who fail to respond to a revalidation request.
- Continue to order site visits; however, the national site visit contractor will continue to perform observational or drive by site visits only.
- Continue to require that all changes, temporary or otherwise, be submitted via the appropriate CMS-855 application

First Coast will communicate any changes to the provisions and waivers currently in place so stay tuned to *eNews*.

For additional assistance, visit our dedicated *coronavirus* page.

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 *www.hhs.gov/provider-relief/index.html*

PPS

Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update

***Note**: We revised this article on March 24, 2020, to announce a delay until further notice to the activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations. This information was previously published in the September 2019 Medicare A Connection, pages 27-28.*

Provider type affected

This MLN Matters® Special Edition Article is for Outpatient Prospective Payment System (OPPS) providers that have multiple service locations submitting claims to Medicare A/B Medicare Administrative Contractors (MACs).

What you need to know

This article conveys the activation of systematic validation edits to enforce the requirements in the Medicare Claims Processing Manual, Chapter 1, Section 170, which describes Payment Bases for Institutional Claims. These requirements are not new requirements. The Centers for Medicare & Medicaid Services (CMS) discussed these requirements in CRs 9613 and 9907, both of which were effective on January 1, 2017. MLN Matters articles for CRs 9613 and 9907 are available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/Downloads/MM9613.pdf* and *https://www.cms.gov/Outreach-andEducation/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9907.pdf*, respectively. On March 24, 2020, CMS announced a delay until further notice to the activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations. Make sure your billing staff is aware of these instructions.

Background

Increasingly, hospitals operate an off-campus, outpatient, provider-based department of a hospital. In some cases, these additional locations are in a different payment locality than the main provider. For Medicare Physician Fee Schedule (MPFS) and OPPS payments to be accurate, CMS uses the service facility address of the off-campus, outpatient, provider-based department of a hospital facility to determine the locality in these cases.

Claim Level Information

Medicare outpatient service providers report the service facility location for an off-campus, outpatient, provider-based department of a hospital in the 2310E loop of the 837 institutional claim transaction. Direct Data Entry (DDE) submitters also must report the service facility location for an off-campus, outpatient, provider-based department of a hospital. Paper submitters report the service facility address information in Form Locator (FL) “01” on the paper claim form. For MPFS services, Medicare systems use this service facility information to determine the applicable payment method or locality whenever it is present.

Additionally, Medicare systems will validate service facility location to ensure services are provided in a Medicare enrolled location. The validation will be exact matching based on the information on the Form CMS-855A submitted by the provider and entered into the Provider Enrollment, Chain and Ownership System (PECOS). Providers need to ensure that the claims data matches their provider enrollment information.

When all the services rendered on the claim are from the billing provider address, providers are:

- To report the billing provider address only in the billing provider loop 2010AA and not to report any service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters).

When all the services rendered on the claim are from one campus of a multi-campus provider that reports a billing provider address, providers are:

- To report the campus address where the services were rendered in the service facility location in loop 2310E if the service facility address is different from the billing provider address loop 2010AA (or in DDE MAP 171F screen for DDE submitters).

When all the services rendered on the claim are from the same off-campus, outpatient, provider-based department of a hospital, providers are:

- To report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop 2310E (or in DDE MAP 171F screen for DDE submitters).

When there are services rendered on the claim from multiple locations:

- If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters).
- If any services on the claim were rendered at more than one of the campus locations of a multi-campus provider that is not the main billing provider address, providers should report the service facility address in loop 2310E if all of the service facility addresses are different from the billing provider address in loop 2010AA (or in DDE MAP 171F screen for DDE submitters) from the first registered campus encounter of the “From” date on the claim.
- If any services on the claim were rendered at one of the campus locations of a multi-campus

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provider that is not the main billing provider address and services were also rendered at other off-campus department practice locations, providers should report the campus address where the services were rendered in the service facility location in loop 2310E if the service facility address is different from the billing provider address in loop 2010AA (or in DDE MAP 171F screen for DDE submitters).

- If no services on the claim were rendered at the billing provider address or any campus location of a multi-campus provider, providers should report the service facility address in loop 2310E (or in DDE MAP 171F screen for DDE submitters) from the first registered department practice location encounter of the "From" date on the claim

National Testing

Round 1 Testing

During the week of July 23, 2018, through July 30, 2018, CMS performed a national trial activation of the FISS Edits 34977 and 34978 in production environments. Reason Codes 34977 (claim service facility address doesn't match provider practice file address) and 34978 (Off-campus provider claim line that contains a HCPCS must have a PN or PO) were activated. The testing was transparent to providers as most claims impacted by the test were suspended for one (1) billing cycle and then editing was turned off so the claim could continue processing as normal.

This national test brought to light that many providers are not sending the correct exact service facility location on the claim that produces an exact match with the Medicare enrolled location as based on the information entered into the PECOS for their off-campus provider departments.

Most discrepancies had to do with spelling variations. For example, in PECOS, the word entered was "Road" as part of their address, but the provider entered "Rd" or "Rd." as part of their address on the claim submission. Another example, in PECOS the word entered was "STE" as part of their address, but the provider entered "Suite" as part of their address on the claim submission.

Round 2 Testing

Providers should also ensure that all practice locations are present in PECOS and if any locations are not in PECOS to submit the 855A to add the location(s). Providers can review their practice locations in PECOS and/or the confirmation letter from PECOS when they last enrolled that was received from their A/B MAC to ensure that their service facility address for their off-campus provider department locations provided on claims is an exact match.

CMS conducted a second round of national testing in November 2018. Providers should have used the time before this national testing to correct the off-campus

provider department location addresses within their billing systems to match exactly PECOS for their off-campus provider departments.

Round 3 Testing

Prior to conducting round 3 testing, CMS issued instructions to the FISS maintainer to make the practice location address screen available to providers in DDE at the April 2019 system quarterly release. Starting in April 2019, the practice location screen will be available in DDE. CMS has postponed full production implementation for three additional months to allow time for providers to adjust to the new practice location screen. CMS will continue with additional round(s) of testing to ensure that we have a smooth implementation of the edits. CMS plans to conduct a June 2019 national testing to ensure providers have used the new practice location screen tool and made necessary claims submission updates to their systems.

Round 3 Testing Update & Full Production Delayed Another Quarter

CMS has completed round 3 testing. We are in the process of analyzing the data, but at this point, we have discovered no major issues during round 3 testing. Based on stake-holder comments and to allow additional time to review the round 3 testing, however, CMS has decided to postpone full production implementation until further notice. Once full production is implemented, CMS will direct A/B MACs to permanently turn on the edits and set them up to Return-to-Provider (RTP) claims that do not exactly match. Providers can make corrections to their service facility address for a claim submitted in the DDE MAP 171F screen for DDE submitters. **Providers who need to add a new or correct an existing practice location address will still need to submit a new 855A enrollment application in PECOS.**

CMS expects that the 3 year time frame that the edits have not been active have provided ample time for providers to validate their claims submission system and the PECOS information for their off-campus provider departments are exact matches.

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Additional information

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
March 24, 2020	We revised the article to announce a delay until further notice to the activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations
September 5, 2019	We revised the article to announce a delay of full implementation until April 2020.
June 28, 2019	We revised this article to provide an update on Round 3 testing and to announce a delay of full implementation until October 2019.
March 26, 2019	Initial article released

MLN Matters® Number: SE19007 *Revised*
Article Release Date: March 24, 2020
Related CR Transmittal Numbers: R1704OTN and R1783OTN
Related Change Request (CR) Number: 9613; 9907
Effective Date: N/A
Implementation N/A

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

This section of *Medicare A 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.

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with ***First Coast's fee schedule lookup***. This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Revised LCDs/Articles

Revision to the Part A and Part B billing and coding article A56484

Article ID number: A56484 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 11655 (International Classification of Diseases, 10th Revision [ICD-10] and Other Coding Revisions to National Coverage Determinations [NCDs]-July 2020 Update), the "ICD-10 Codes that Support Medical Necessity/Group 1 Codes:" section of the billing and coding article for bone mineral density studies was revised to add ICD-10-CM diagnosis code Z79.818 for Current Procedural Terminology (CPT®) codes 77080, 77085, and 0508T.

Effective date

This billing and coding article revision is effective for claims processed **on or after March 24, 2020** for services rendered **on or after January 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 (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*.

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 change request (CR) 11550, 11680, 11691, and 11694 (April 2020 Quarterly Updates), the "CPT®/HCPCS Codes/Group 1 Paragraph/Group 1 Codes:" sections of the pegfilgrastim billing and coding article were revised to remove Healthcare Common Procedure Coding System (HCPCS) code C9399 and to add HCPCS code C9058.

Effective date

This billing and coding article revision is effective for services rendered **on or after April 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 (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*.

Transthoracic echocardiography (TTE) - revision to the Part A and Part B billing and coding article

Article ID number: A57182 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a review of the billing and coding article for transthoracic echocardiography (TTE), the billing and coding article was revised to add ICD-10-CM diagnosis code Z01.810 to the "ICD-10 Codes that Support Medical Necessity/Group 1 Codes:" section.

Effective date

This billing and coding article revision is effective for services rendered **on or after April 9, 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 (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*.

Molecular pathology procedures - revision to the Part A and Part B Billing and Coding Article

Article ID number: A57451 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 11550, 11680, 11681, and 11691 (April 2020 Quarterly Updates), the "CPT®/HCPCS Codes/Group 1 Codes:" section of the billing and coding article for molecular pathology procedures was updated to revise the descriptors for Current Procedural Terminology (CPT®) codes 0154U and 0155U.

Effective date

This billing and coding article revision is effective for services rendered **on or after April 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 (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*.

Allergy testing - revision to the Part A and Part B billing and coding article

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

Based on change request (CR) 11550, 11680, 11681, and 11691 (April 2020 Quarterly Updates), 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 were revised to add Current Procedural Terminology (CPT®) code 0165U.

Effective date

This billing and coding article revision is effective for services rendered **on or after April 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 (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*.

Retired LCDs/Articles

Multiple Part A and Part B LCDs and billing and coding articles being retired

LCD and Article ID numbers: L34006/A57777, L34017/A57470, L34025/A57542, L34031/A57197 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of the following local coverage determinations (LCDs) and billing and coding articles, it was determined that they are no longer required and therefore, are being retired.

- L34006/A57777 - Interspinous Process Decompression
- L34017/A57470 - Ophthalmoscopy
- L34025/A57542 - Surgical Decompression for Peripheral Polyneuropathy
- L34031/A57197 - Total Calcium

Effective date

The retirement of these LCDs and billing and coding articles is effective for services rendered **on or after April 4, 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 (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*.

Manipulation under anesthesia - retired Part A and Part B LCD and billing and coding article

LCD and Article ID number: L33594/A57766 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) and billing and coding article for manipulation under anesthesia, it was determined that the LCD and billing and coding article 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 April 3, 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 (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*.

Prostatic urethral lift (PUL) - retired Part A and Part B LCD and billing and coding article

LCD and Article ID number: L36775/ A57801 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) and billing and coding article for prostatic urethral lift (PUL), 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 April 3, 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 (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*.

Internet-based PECOS training by appointment

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. Please email *elearning@fcso.com* to request an appointment.

Upcoming provider outreach and educational events

Evaluation and management (E/M): Hospital services – are you coding correctly?

Date: April 30
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 - 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. 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*.

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

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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: *https://www.cdc.gov/coronavirus/2019-ncov/index.html*. For information specific to CMS, please visit the *Current Emergencies Website*.

MLN Connects® for March 19, 2020

MLN Connects® for Thursday, March 19, 2020

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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

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.

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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® for March 26, 2020

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 for March 26, 2020

COVID-19: Enrollment relief, open payments, beneficiary notices

- *2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs)*
- *Frequently Asked Questions (FAQs) on Enforcing Open Payments Deadlines*
- *Beneficiary Notice Delivery Guidance in light of COVID-19*

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

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- 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 Newsoom* external.gif and *Current Emergencies Website*.

MLN Connects® – Special Edition for March 30, 2020

COVID-19: Financial Relief, Nursing Home Telehealth, Quality Reporting, Clinical Laboratories, Hospital Data

- *Trump Administration Provides Financial Relief for Medicare Providers*
- *Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit*
- *Quality Payment Program and Quality Reporting Program/Value Based Purchasing Program COVID-19 Relief*
- *Clinical Laboratory Improvement Amendments (CLIA) Guidance During COVID-19 Emergency*
- *Trump Administration Engages America's Hospitals in Unprecedented 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

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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: *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 *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

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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 *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 for March 31, 2020

COVID-19: 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*
- *Billing for Professional Telehealth Services During the Public Health Emergency*
- *New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing*

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

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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.

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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 *www.coronavirus.gov.* For a complete and updated list of CMS actions, and other information specific

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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® for April 2, 2020

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 for 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*
- *Trump Administration Issues Key Recommendations to Nursing Homes, State and Local Governments*
- *Billing for Multi-Function Ventilators (HCPCS Code E0467) under the COVID-19 Public Health Emergency and Otherwise*
- *New ICD-10-CM diagnosis code, U07.1, for COVID-19*

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 for 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*
- *Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services*
- *Guidance for Processing Attestations from Ambulatory Surgical Centers (ASCs) Temporarily Enrolling as Hospitals during the COVID-19 Public Health Emergency*
- *COVID-19: Expanded Use of Ambulance Origin/ Destination Modifiers*
- *Lessons from The Front Lines: COVID-19*
- *CMS COVID-19 Update 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 *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

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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.

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

MLN Connects® for April 9, 2020

MLN Connects® for 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 for 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*
- *Trump Administration Acts to Ensure U.S. Healthcare Facilities Can Maximize Frontline Workforces to Confront COVID-19 Crisis*
- *Updated Questions and Answers on COVID-19*
- *Using CS Modifier When Cost-Sharing is Waived*
- *Medicare FFS Claims: 2% Payment Adjustment Suspended (Sequestration)*

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,*

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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 for April 15, 2020

COVID-19: Reprocessing Hospital Claims, Essential Diagnostic Services, Non-Invasive Ventilators

- *IPPS Hospitals, LTCHs: Reprocessing Claims for CARES Act*
- *Trump Administration Announces Expanded Coverage for Essential Diagnostic Services Amid COVID-19 Public Health Emergency*
- *Removal of Non-Invasive Ventilator Product Category from DMEPOS Competitive Bidding Program*

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® for April 16, 2020

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 for 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*
- *CMS Increases Medicare Payment for High-Production Coronavirus Lab Tests*
- *CMS Implements CARES Act Hospital Payment and Inpatient Rehabilitation Facility Waivers*
- *COVID-19 Call: Audio Recording 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.

First Coast Service Options Phone Numbers

***(Note:** Specific geographic contact information is noted when phone numbers and addresses are different for providers in Florida, U.S. Virgin Islands or Puerto Rico.*

Customer service

Monday to Friday
8:00 a.m. to 4:00 p.m
888-664-4112 (FL/USVI)
877-908-8433 (Puerto Rico)
877-660-1759 (TDD-FL/USVI)
888-216-8261 (TDD-Puerto Rico)

Electronic data interchange

888-670-0940 (FL/USVI)
888-875-9779 (Puerto Rico)

Interactive Voice Response

877-602-8816

Overpayments

904-791-6029

SPOT Help Desk

FCSOSPOTHelp@fcso.com
855-416-4199

Provider websites

English
Spanish

First Coast Service Options Addresses

Claims/correspondence

Florida/ U.S. Virgin Islands

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Medicare EDI Electronic claim filing

Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

Fraud and abuse

Complaint Processing Unit
P. O. Box 45087

FOIA requests

Provider audit/reimbursement

(relative to cost reports and audits)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

General Inquiries

Online Form (Click here)
EDOC-CS-FLINQA@fcso.com (FL/USVI)
EDOC-CS-PRINQA@fcso.com (PR)

Local coverage determinations

Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)

Medicare Secondary Payer
P. O. Box 44179
Jacksonville, FL 32231-4179

Hospital audits

MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, auto accident settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections and debt recovery

Repayment, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Credit balance reports

First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

Post-pay medical review

First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment

CMS-855 Applications
P. O. Box 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries
Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Redetermination

Florida:
Medicare Part A Redetermination/Appeals
P. O. Box 3409
Jacksonville, FL 32232-5053

U.S. Virgin Islands:

First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Special delivery/courier services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

DME regional carrier (DMERC)

DME, orthotic, prosthetic device, take-home supply, oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare

Palmetto GBA
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health/hospice intermediary

Palmetto GBA
Medicare Part A
34650 US HWY 19N
Palm Harbor, FL 34684

Contact CMS

Centers for Medicare & Medicaid Services (CMS)

Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations

ROATLFM@CMS.HHS.GOV

Office of Inspector General (OIG)
Medicare fraud hotline
800-HHS-TIPS (800-447-8477)

Beneficiary customer service

1-800-MEDICARE (1-800-633-4227)

Hearing and speech impaired (TDD)
1-800-754-7820