Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

February 2020

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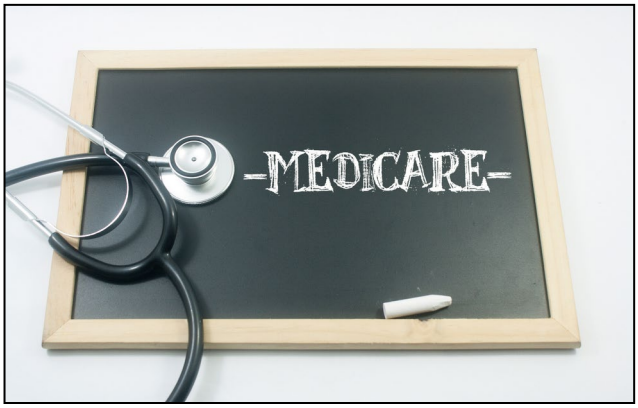
Unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable).

Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks.

Part B contractors generally receive checks. Substantial funds are returned to the trust fund each year through such unsolicited/voluntary refunds.



The Centers for Medicare & Medicaid Services reminds providers that:

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Source: *CMS Pub. 100-06, Chapter 5, Section 410.10*

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

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

About the Medicare B Connection

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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

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

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

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

Never miss an appeals deadline again

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

Medicare Part B advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Reassignment of Medicare benefits: Revised CMS-855R required May 1

Physicians and non-physician practitioners: Use the revised CMS-855R (Reassignment of Benefits) application once it is posted on the CMS forms list in early February 2020. Medicare administrative contractors will accept current and revised versions of the form through April 30, 2020. Starting May 1, 2020, you must use the revised form. Form updates:

- Can select "Change of Reassignment Information" as submission reason
- Option to identify a secondary practice address

Visit the Medicare *Provider-Supplier Enrollment* webpage for more information about Medicare enrollment.

Disaster Information

Provider enrollment relief for Commonwealth of Puerto Rico due to the effects of earthquakes

Effective December 28, 2019, and remaining in effect for a period of 180 days, First Coast implemented provider enrollment relief for providers in Puerto Rico. During this period, we will:

- Refrain from mailing any revalidation letters, including subsequent revalidation letters (i.e., 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.
- Refrain from mailing any new fingerprint-based background check letters. Denial or revocation of providers/suppliers due to non-response to fingerprints shall also be held.
- Extend the 30-day development response requirement up to 90 days, if development is needed.
- Continue to order site visits. However, the national site visit contractor will not perform site visits in the impacted area until the major disaster declaration is lifted.
- Continue to require that all changes, temporary or otherwise, be submitted via the appropriate CMS-855 application.

For additional assistance, visit our dedicated *disaster information* page.

Durable Medical Equipment

2020 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List

Note: *We revised this article on January 31, 2020, to reflect a revised CR 11596 issued on January 30. The revisions to the CR had no impact on the substance of the article. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.*

Provider types affected

This MLN Matters Article is for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) including Durable Medical Equipment (DME MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items, or services paid under the DMEPOS fee schedule.

Provider action needed

CR11596 updates the list of HCPCS codes for MACs and DME MACs. Please make sure your billing staffs are aware of these updates.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) annually updates a spreadsheet that contains a list of the HCPCS codes for DME MAC and Part B MAC jurisdictions to reflect codes that are either added or discontinued (deleted) each year. The jurisdiction list is an Excel file and is available at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html. The list is also attached to CR11596.

Additional Information

The official instruction, CR11596, issued to your MAC regarding this change is available at *https://www.cms.gov/files/document/r4511cp.pdf*. If you have questions, your MACs may have more information. Find their website at *http://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
January 31, 2020	We revised this article to reflect a revised CR 11596 issued on January 30. The revisions to the CR had no impact on the substance of the article. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.
January 17, 2020	Initial article released.

MLN Matters® Number: MM 11596 *Revised*
Related CR Release Date: January 30, 2020
Related CR Transmittal Number: R4511CP
Related Change Request (CR) Number: 11596
Effective Date: January 1, 2020
Implementation date: February 18, 2020

Your Feedback Matters

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

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

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.*

New LCDs / Articles

Cardiology non-emergent outpatient stress testing – new Part A and Part B LCD

LCD/Article ID number: L38396/A56952 (Florida, Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) addresses "Coverage Indications, Limitations, and/or Medical Necessity", and "Provider Qualifications" requirements for cardiac non emergent outpatient stress testing: exercise stress testing, stress echocardiography, single photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), positron emission tomography (PET) MPI, and stress cardiac magnetic resonance imaging (MRI).

Also, the related billing and coding article (A56952) addresses coding guidelines in support of the reasonable and necessary services as outlined in the LCD.

The current LCD (L36209) and related billing and coding article (A57076) will be retired when this new LCD and related billing and coding article become effective.

Effective date

This new LCD and related billing and coding article are effective for services rendered **on or after March 15, 2020**.

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

A coding article for an LCD 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*.

Hypoglossal nerve stimulation for the treatment of obstructive sleep apnea – new Part A and Part B LCD

LCD/Article ID number: L38398/A56953 (Florida, Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) provides limited coverage for hypoglossal nerve stimulation for the treatment of obstructive sleep apnea when a Food and Drug Administration (FDA) approved hypoglossal nerve stimulator is utilized.

This new LCD addresses "Coverage Indications, Limitations, and/or Medical Necessity" and "Provider Qualifications".

Also, the related billing and coding article (A56953) addresses coding guidelines in support of the reasonable and necessary services as outlined in the LCD.

Effective date

This new LCD and related billing and coding article are effective for services rendered **on or after March 15, 2020**.

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

A coding article for an LCD 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*.

First Coast provider enrollment videos

First Coast Service Options has educational videos dedicated to common questions about the provider enrollment process. These videos are only three-to-five minutes long and they offer you an intercative way to learn.

Revised LCDs / Articles

Trastuzumab – trastuzumab biologics -- revision to the Part A and Part B Billing and Coding Article

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

Based on change request (CR) 11605, the status indicator for Healthcare Common Procedure Coding System (HCPCS) code Q5114 changed from "E2" to "K". Therefore, it was added to the "CPT®/HCPCS Codes/ Group 1 Codes" section of the Billing and Coding article.

Effective date

This billing and coding article revision is effective for claims processed **on or after January 6, 2020**, for services rendered **on or after November 29, 2019**.

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

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

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

BRCA1 and BRCA2 genetic testing -- revision to the Part A and Part B Billing and Coding Article

Article ID number: A57449 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on further review of the BRCA1 and BRCA2 genetic testing billing and coding article, the "CPT®/HCPCS Codes/Group 1 Codes:" section of the billing and coding article was revised to add Current Procedural Terminology (CPT®) code 81433 and to remove Proprietary Laboratory Analyses (PLA) codes 0129U, 0131U, 0132U, 0135U, 0137U and 0138U.

Effective date

This billing and coding article revision is effective for services rendered **on or after February 8, 2020**.

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

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

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

Therapy and rehabilitation services -- revision to the Part A and Part B Billing and Coding Article

Article ID number: A57156 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of the billing and coding article, the "CPT®/HCPCS Codes" section was revised.

The "Group 2 Codes:" section was revised to add Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) codes 97116, 97032, G0283, 97024, and 97035.

Effective date

This billing and coding article revision is effective for claims processed **on or after February 20, 2020**.

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

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

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

Noncovered services -- revision to the Part A and Part B Billing and Coding Article

Article ID number: A57743 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on further review of the noncovered services billing and coding article, vaccine Current Procedural Terminology (CPT®) codes 90620, 90621, 90644, 90650 and 90681 were removed from the "CPT®/HCPCS Codes/ Group 1 Codes:" section of the billing and coding article and vaccine CPT® codes 90476, 90477, 90581, 90585, 90632, 90633, 90634, 90647, 90648, 90649, 90680, 90690 and 90691 were removed from the "CPT®/HCPCS Codes/Group 2 Codes:" section of the billing and coding article as they have no preventive benefit.

The Centers for Medicare & Medicaid Services (CMS) may add coverage of preventive vaccine services through the Medicare Benefit Policy Manual under Section 1861(s)(10) of the Social Security Act.

Effective date

This billing and coding article revision is effective for services rendered **on or after February 20, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Retired LCDs / Articles

Hepatitis B surface antibody and surface antigen -- retirement to the Part A and Part B LCD and Billing and Coding Article

LCD and Article ID number: L34003/A57057 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of the local coverage determination (LCD) and Billing and Coding Article, it was determined that the LCD and Billing and Coding Article were 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 February 12, 2020**.

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

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

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

Multiple Part A and Part B LCDs being retired

LCD and Article ID numbers: L33296/A57769/ A54815, L33283/A57652

(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.

L33296/A57769/A54815 - Noncovered Procedures-Endoscopic Treatment of Gastroesophageal Reflux Disease (GERD)

L33283/A57652 - Computed Tomographic Colonography.

Effective date

The retirement of these LCDs and billing and coding articles is effective for services rendered **on or after February 14, 2020**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Upcoming provider outreach and educational events

Medicare Quarterly Updates (B)

Date: March 18, 2020
Time: 11 a.m. - 12:30 p.m. ET
Type of Event: Webcast

View our complete calendar of events

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

Two easy ways to register

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

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects®

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

MLN Connects® for January 23, 2020

MLN Connects® for January 23, 2020

View this edition as a PDF

News

- Medicare Learning Network Celebrates 20 Years
- CMS Updates Open Payments Data
- Open Payments Search Tool: New Features
- Shoulder Arthroscopy: Comparative Billing Report in January
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- Issues Viewing the CMS Website?
- Continue Seasonal Influenza Vaccination through January and Beyond

Compliance

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- Listening Sessions on MAC Opportunities to Enhance Provider Experience — January 29
- Shoulder Arthroscopy: Comparative Billing Report Webinar — February 4
- CMS Quality Conference — February 25-27
- Highly Pathogenic Infectious Disease Training and Exercise Resources Webinar — March 5

MLN Matters® Articles

- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.1, Effective April 1, 2020
- 2020 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List
- Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens
- Home Health (HH) Patient-Driven Groupings Model (PDGM) - Split Implementation — Revised
- Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System — Revised

Publications

- Quality Payment Program: 2020 Resources

Multimedia

- Quality Payment Program: 2019 Data Submission Videos
- Health Care Challenges in Chemical Incidents Webinar Recording
- Infection Prevention and Control: Environmental Safety Web-Based Training Course — Revised
- Infection Prevention and Control: Hand Hygiene Web-Based Training Course — Revised
- Infection Prevention and Control: Injection Safety Web-Based Training Course — Revised

MLN Connects® for January 30, 2020

MLN Connects® for January 30, 2020

View this edition as a PDF

News

- CMS Expands Coverage of NGS as Diagnostic Tool for Patients with Breast and Ovarian Cancer
- Nursing Home Quality Initiative: Draft MDS 3.0 Item Set Change History
- Nursing Homes: Use Updated Infection Control Worksheet
- Glaucoma Awareness Month: Make a Resolution for Healthy Vision

Compliance

- Hospice Care: Safeguards for Medicare Patients

Claims, Pricers & Codes

- OPPS Pricer File: January 2020

Events

- Ground Ambulance Organizations: Reporting Staff and Labor Costs Open Door Forum — February 6
- Ground Ambulance Organizations: Reporting Volunteer Labor Call — February 20

MLN Matters® Articles

- Increasing Access to Innovative Antibiotics for Hospital Inpatients Using New Technology Add-On Payments: Frequently Asked Questions
- January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder
- 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
- Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

Publications

- Safeguards for Medicare Patients in Hospice Care
- Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B — Revised
- Skilled Nursing Facility Prospective Payment System — Revised

Multimedia

- ESRD Quality Incentive Program: Audio Recording and Transcript
- MAC Listening Session: Audio Recording and Transcript

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*.

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News

- Open Payments Registration
- Promoting Interoperability Programs: Deadline to Submit 2019 Data is March 2
- Quality Payment Program: Updated Explore Measures Tool
- Quality Payment Program: MIPS 2020 Call for Measures and Activities
- Medicare Promoting Interoperability Program: Requirements for 2020
- SNF Quality Reporting Program: FY 2022 APU Table
- Reassignment of Medicare Benefits: Revised CMS-855R Required May 1
- February is American Heart Month

Compliance

- Outpatient Rehabilitation Therapy Services: Comply with Medicare Billing Requirements

Claims, Pricers & Codes

- ICD-10-CM: New Diagnosis Code for Vaping-related Disorders Effective April 1

Events

- Substance Use Disorders: Availability of Benefits Listening Session — February 18
- Ground Ambulance Organizations: Reporting Volunteer Labor Call — February 20
- Dementia Care: CMS Toolkits Call — March 3
- Part A Providers: QIC Appeals Demonstration Call — March 5

MLN Matters® Articles

- Provider Enrollment Appeals Procedure
- Quarterly Influenza Virus Vaccine Code Update — July 2020
- 2020 Annual Update to the Therapy Code List — Revised
- 2020 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List — Revised

Publications

- Medicare Mental Health
- Medicare Provider Enrollment

Multimedia

- MAC Listening Session: Audio Recording and Transcript

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News

- DMEPOS Items Subject to Prior Authorization
- Influenza Activity Continues: Are Your Patients Protected?

Compliance

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

Events

- Substance Use Disorders: Availability of Benefits Listening Session — February 18
- Ground Ambulance Organizations: Reporting Volunteer Labor Call — February 20
- Dementia Care: CMS Toolkits Call — March 3
- Hospice Item Set Data Submission Requirements Webinar — March 3
- Part A Providers: QIC Appeals Demonstration Call — March 5
- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12

MLN Matters® Articles

- Update to the Home Health Grouper for New Diagnosis Code for Vaping Related Disorder
- Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy
- Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder — Revised
- January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised

Publications

- Diabetes Management Resources
- Caring for Medicare Patients is a Partnership — Revised

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- MAC Listening Session: Audio Recording and Transcript

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