RAILROAD MEDICARE ADVISORY

Latest Part B News for Railroad Medicare

January 2021
Volume 2021, Issue 1

What's Inside...

Administration

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

Electronic Data Interchange (EDI)

Continued >>

palmettogba.com/rr

The *Medicare Advisory* contains coverage, billing and other information for Railroad Medicare. This information is not intended to constitute legal advice. It is our official notice to those we serve concerning their responsibilities and obligations as mandated by Medicare regulations and guidelines. This information is readily available at no cost on the Palmetto GBA website. It is the responsibility of each facility to obtain this information and to follow the guidelines. The *Railroad Medicare Advisory* includes information provided by the Centers for Medicare & Medicaid Services (CMS) and is current at the time of publication. The information is subject to change at any time. This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no-cost from our website at **https://www.PalmettoGBA.com/rr**.

A RRB-Contracted Specialty Medicare Administrative Contractor

PALMETTO GBA®
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Fee Schedules and Reimbursement

Medicine

Laboratory

Therapy

Etcetera

eServices: COVID-19 Transition

In light of the COVID-19 pandemic, organizations are proactively transitioning employees across the health care industry back into the office.

Palmetto GBA is providing a quick reference eServices guide to assist with common issues you may experience if you have not logged into your eServices account in the past 30-60 days.

If you are not currently registered to use eServices, we have also included some resources to get you started.

Railroad Medicare:
https://www.palmettogba.com/internet/PCIDN.nsf/R?OpenAgent&DID=BRKJM375&url=yes

CMS Provider Minute Videos

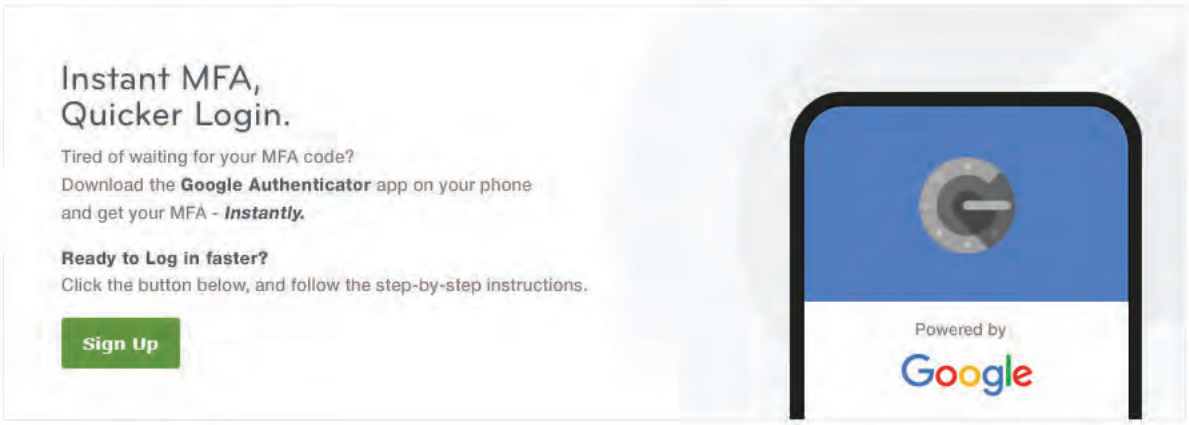
The Medicare Learning Network has a series of CMS Provider Minute Videos (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia) on a variety of topics, such as psychiatry, preventive services, lumbar spinal fusion, and much more. The videos offer tips and guidelines to help you properly submit claims and maintain sufficient supporting documentation. Check the site often as CMS adds new videos periodically to further help you navigate the Medicare program.

Do You Have a Question Regarding eServices? We Can Help!

Palmetto GBA has dedicated representatives available to provide technical assistance and answer questions about our secure online portal — eServices. *Our Provider Contact Center (PCC) representatives* can be reached at 888-355-9165 (Monday – Friday, 8:30 a.m. to 4:30 p.m. ET for all time zones with the exception of PT, which receives services from 8 a.m. to 4 p.m.).

To connect with an eServices representative:
- Press 2 for EDI/eServices, then
- Press 1 for eServices inquiries

eServices and Google Authenticator



To enhance the security of Medicare information, the Centers for Medicare & Medicaid Services (CMS) requires the use of multi-factor authentication (MFA) each time you log in to eServices. We're excited to announce a new option to protect your account - Google Authenticator.

You now have three options to receive an MFA code:
- Email
- Text
- Google Authenticator

Are you new to eServices? Or maybe you already have an eServices account...no worries! In just a few quick steps, you can set up Google Authenticator. This two-step verification is available when initially registering for eServices or if you already have an existing eServices account.

Initial Registration
Upon initial registration to eServices, you must complete the fields on the MFA Setup screen.

The information entered on this screen will be saved in your profile. Select Authenticator Setup for Google Authenticator option.

After selecting the Authenticator Setup button, you'll see instructions for installing Google Authenticator. These steps are based on your device - iPhone or Android:
- iPhone users must access iTunes
- Android users must access Google Play

A successful installation prompts this screen showing your device is now linked. Select Submit to save the changes.

At your initial login to eServices, you are asked to choose your preferred method for receiving your MFA code.

Select the Use the app button to receive the MFA code via the Google Authenticator app.

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After selecting Use the app, the verification code will appear in your Google Authenticator app. This code will renew every 30 seconds.

Enter the code in the available field and select the Submit button.

Existing Account
At your next login to eServices, you are asked to choose your preferred method for receiving your MFA code.

You must choose from the text or email options since you haven't set up the Google Authenticator option yet.

After verification, go to the My Account tab to change your account settings.

From the My Account tab, scroll down until you see the MFA Setup options.

The information entered on this screen will be saved in your profile. Select Authenticator Setup for Google Authenticator option.

After selecting the Authenticator Setup button, you'll see instructions for installing Google Authenticator. These steps are based on your device - iPhone or Android:

- iPhone users must access iTunes
- Android users must access Google Play

A successful installation prompts this screen showing your device is now linked. Select Submit to save the changes.

At your next login to eServices, you are again asked to choose your preferred method for receiving your MFA code. But not you'll notice you can also choose to receive your code with the Google Authenticator app.

Select the Use the app button to receive the MFA code via the Google Authenticator app.

After selecting Use the app, the verification code will appear in your Google Authenticator app. This code will renew every 30 seconds.

Enter the code in the available field and select the Submit button.

Get Your Medicare News Electronically

The Palmetto GBA Medicare listserv is a wonderful communication tool that offers its members the opportunity to stay informed about:

- Medicare incentive programs
- Fee Schedule changes
- New legislation concerning Medicare
- And so much more!

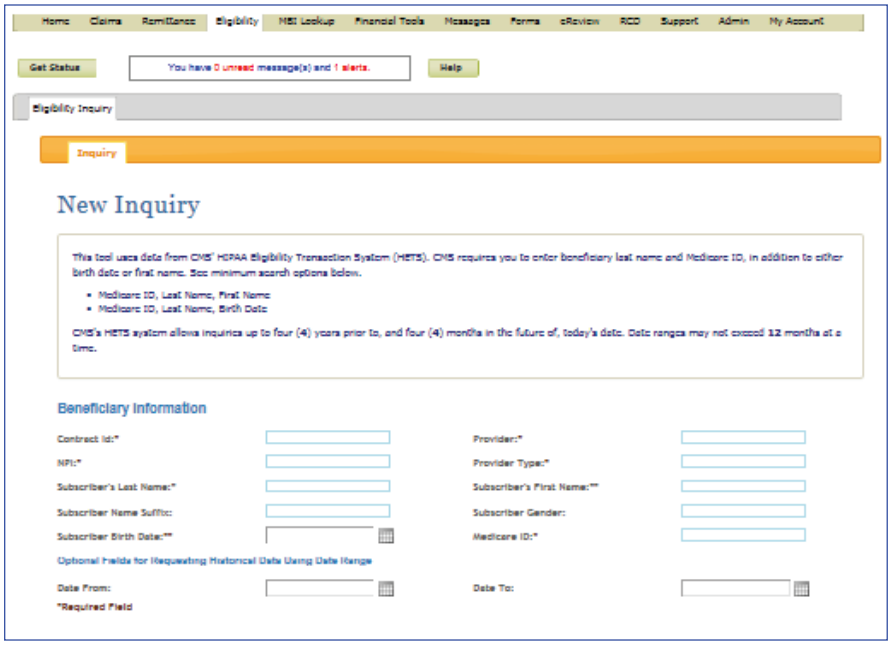
How to register to receive the Palmetto GBA Medicare Listserv: Go to http://tinyurl.com/PalmettoGBAListserv and select "Register Now." Complete and submit the online form. Be sure to select the specialties that interest you so information can be sent.

Note: Once the registration information is entered, you will receive a confirmation/welcome message informing you that you've been successfully added to our listserv. You must acknowledge this confirmation within three days of your registration.

eServices Eligibility

eServices, by Palmetto GBA, allows you to search for patient eligibility, which is a functionality of HETS. HETS requires you to enter beneficiary last name and Medicare ID Number, in addition to either the birth date or first name. See options below:

- Medicare ID Number, Last Name, First Name, Birth Date
- Medicare ID Number, Last Name, Birth Date
- Medicare ID Number, Last Name, First Name



For more information about eServices and the many services it offers, please visit our website at http://www.PalmettoGBA.com/eServices.

Medicare Learning Network® (MLN)

Want to stay informed about the latest changes to the Medicare Program? Get connected with the Medicare Learning Network® (MLN) – the home for education, information, and resources for health care professionals.

The Medicare Learning Network® is a registered trademark of the Centers for Medicare & Medicaid Services (CMS) and the brand name for official CMS education and information for health care professionals. It provides educational products on Medicare-related topics, such as provider enrollment, preventive services, claims processing, provider compliance, and Medicare payment policies. MLN products are offered in a variety of formats, including training guides, articles, educational tools, booklets, fact sheets, web-based training courses (many of which offer continuing education credits) – all available to you free of charge!

The following items may be found on the CMS web page at:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index

- MLN Catalog: is a free interactive downloadable document that lists all MLN products by media format. To access the catalog, scroll to the "Downloads" section and select "MLN Catalog." Once you have opened the catalog, you may either click on the title of a product or you can click on the type of "Formats Available." This will link you to an online version of the product or the Product Ordering Page.
- MLN Product Ordering Page: allows you to order hard copy versions of various products. These products are available to you for free. To access the MLN Product Ordering Page, scroll to the "Related Links" and select "MLN Product Ordering Page."
- MLN Product of the Month: highlights a Medicare provider education product or set of products each month along with some teaching aids, such as crossword puzzles, to help you learn more while having fun!

Other resources:

- MLN Publications List: contains the electronic versions of the downloadable publications. These products are available to you for free. To access the MLN Publications go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications. You will then be able to use the "Filter On" feature to search by topic or key word or you can sort by date, topic, title, or format.

MLN Educational Products Electronic Mailing List

To stay up-to-date on the latest news about new and revised MLN products and services, subscribe to the MLN Educational Products electronic mailing list! This service is free of charge. Once you subscribe, you will receive an e-mail when new and revised MLN products are released.

To subscribe to the service:

1. Go to https://list.nih.gov/cgi-bin/wa.exe?A0=mln_education_products-l and select the 'Subscribe or Unsubscribe' link under the 'Options' tab on the right side of the page.
2. Follow the instructions to set up an account and start receiving updates immediately – it's that easy!

If you would like to contact the MLN, please email CMS at MLN@cms.hhs.gov.

ePass is Now Available in the Railroad Medicare Interactive Voice Response (IVR) Unit

Provider authentication by Provider Transaction Access Number (PTAN), National Provider Identifier (NPI) and Tax Identification Number (TIN) is required before the Palmetto GBA Interactive Voice Response (IVR) Unit is authorized to release Railroad Medicare claim status information, financial information, patient eligibility information, or to order a copy of a remittance advice.

An "ePass" is an eight-digit code you will be prompted to receive or enter each time you choose the IVR options for claims, finance, eligibility or duplicate remittance advice. When you choose option 2 to receive an ePass, you will be assigned an ePass code for the provider's PTAN/NPI/TIN combination you enter. You can then enter that ePass in the IVR for the remainder of the day in order to authenticate that provider. This eliminates the need to repeatedly enter the same PTAN, NPI and TIN into the IVR.

The goal of the ePass is to ease provider burden by eliminating the need to repeatedly authenticate the same provider each time you contact the IVR in a given day.

We hope this service will be effective and helpful to you. We encourage you to give us feedback about ePass through our website satisfaction survey. Your input helps us create new tools (like ePass) to make interacting with Railroad Medicare smooth and easy. To access the survey, access the "Topics" in the drop down menu at the top of this web page. The last item on the preview says "You Do Make a Difference," which is the link to the survey.

We look forward to hearing from you!

CMS Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The purpose of the Quarterly Provider Update is to:

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

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update listserv (electronic mailing list) at https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&qsp=566.

We encourage you to bookmark the Quarterly Provider Update Web site at www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index and visit it often for this valuable information.

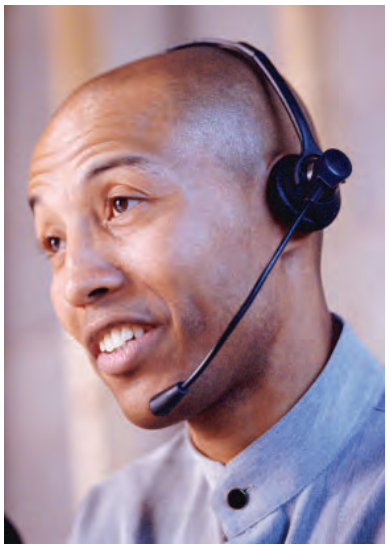
eServices Extends Administrator Unlock Feature Beyond 30 Days

Palmetto GBA has implemented new "Disable User" functionality in eServices that will disable a user that has been inactive for 30 days instead of terminating the User ID. Administrators will now be able to enable the user up to 120 days after 30 days of inactivity. If the user ID is not enabled within this time, the account will be terminated. We will send notification to providers through a series of periodic emails (up to the 120-day limit) to remind the user of their status and provide instructions to re-enable eServices IDs.

In short, provider administrators can now simply unlock users as well as other administrators. This is a significant change from past guidelines. Previously:

- Provider Administrators and users were required to login at least once every 30 days
    - Accounts in which users did not login past 30 days were deactivated/terminated
        - If the provider admin did not login, all user accounts associated with the provider admin were also deactivated/terminated
- This created additional work for administrators as they were required to create new accounts for deactivated/terminated users

The Provider Contact Center eServices Helpdesk is also able to assist if the provider administrator is unable to complete this task.



Provider Customer Service Center Training and Closure Dates

The Centers for Medicare & Medicaid Services (CMS) and the Railroad Retirement Board (RRB) have approved the RRB Specialty Medicare Administrative Contractor (RRB SMAC) to close up to eight hours per month for provider Customer Service Advocates (CSAs) training and/or staff development. The goal is to help CSAs improve the consistency and accuracy of their responses to provider questions; enhance their awareness and understanding of Medicare policies and issues; and facilitate CSAs' retention of the facts of their training by increasing its frequency.

When our CSAs participate in training and developmental sessions on Thursdays of each month, you may use our online provider portal called eServices. eServices provides claim status, duplicate remittances, patient eligibility and much more. Register now at https://www.PalmettoGBA.com/eServices. Please refer to the training schedule below for specific closure dates and times.

Date	Phones Closed
December 24, 2020	Office closed / Christmas Eve
December 25, 2020	Office closed / Christmas Day
December 31, 2020	PCC closed for training / 2:30 to 4:30 p.m. ET
January 1, 2021	Office closed / New Year's Day
January 7, 2021	PCC closed for training / 1:30 to 4:30 PM ET
January 14, 2021	PCC closed for training / 2:30 to 4:30 PM ET
January 18, 2021	Office closed / Martin Luther King Jr.'s Birthday
January 28, 2021	PCC closed for training / 1:30 to 4:30 PM ET
May 31, 2021	Office closed / Memorial Day
July 5, 2021	Office closed / Independence Day
September 6, 2021	Office closed / Labor Day
November 25, 2021	Office closed / Thanksgiving Day
November 26, 2021	Office closed / Day After Thanksgiving
December 23, 2021	Office closed / Christmas Eve
December 24, 2021	Office closed / Christmas Day
December 31, 2021	Office closed / New Year's Day

Please note that we will attempt to provide advance notice of any changes to the above training schedule via the website, IVR features and automatic email notices.

If you have not already done so, we encourage you to sign up for automatic email notices of updates to our website. Subscribing to this listserv is the fastest way to find out about Medicare changes that may affect you. There is no charge for the service, and we will not share your email address with others. To register, go to Email Updates at https://www.palmettogba.com/registration.nsf/Push+Mail+Archive+Home?OpenForm.

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If you have questions, please call our Provider Contact Center at 888-355-9165 and select Option 5. Customer Service Advocates are available between the hours of 8:30 a.m. to 4:30 p.m. for all time zones, with the exception of PT, which receives service from 8 a.m. to 4 p.m. PT. Our eServices portal is available 24/7 with the exception of claims, remittance, and financial data, which is available from 8 a.m. to 7 p.m. Monday through Friday. You may access eServices at http://www.PalmettoGBA.com/eServices.

eDelivery Reminder: Are You Getting Your Greenmail?

Palmetto GBA would like to remind providers that you have the option to receive letters electronically through eServices. Gaining access to these letters is a simple process! To start receiving your Medicare letters, such as Medical Review Additional Documentation Request (ADR) letters and first level appeal Medicare Redetermination Notices (MRNs) electronically, you must be signed up for our eServices online provider portal. Once you have signed into eServices, select the Admin tab, next you can choose your eDelivery preferences. Just click the drop down box to choose eDelivery of the letters you would like to receive via greenmail. You can also select "User Email Notification" to start receiving emails when your letters are available in eServices for you. Selecting this choice is so easy and allows you to receive your letters faster!

Once you have chosen the eDelivery option, all of the letters you selected will come to you electronically, even if you sent in your request via fax or mail.

Using MBIs in the IVR Now

The transition period during which you can use either a patient's Health Insurance Claim Number (HICN) or a Medicare Beneficiary Identifier (MBI) ended on December 31, 2019. All Railroad Medicare systems including our Interactive Voice Response (IVR) requires MBIs to obtain beneficiary and claims information.

Need help using MBIs in the IVR? Our IVR Conversion Tool can help! Use our IVR Conversion Tool (https://www.palmettogba.com/internet/PCIDN.nsf/R?OpenAgent&DID=BBBRUD68&url=yes) to quickly convert an MBI into the numbers/characters that are required by our IVR. This tool also converts your Provider Transaction Access Number (PTAN) and your patient's name.

As an alternative to the IVR, providers with an Electronic Data Interchange (EDI) enrollment agreement on file with Palmetto GBA Railroad Medicare and a claim in history can use Palmetto GBA's eServices online provider portal to check claim status and patient eligibility, to view and print remittance advice, and more. If you are already submitting claims electronically to Railroad Medicare, you do not have to submit a new EDI Enrollment Agreement. Register for eServices today at https://www.PalmettoGBA.com/eservices.

How Can I Tell if a Patient Has Railroad Medicare?

All Railroad Medicare beneficiaries have been mailed their new Railroad Medicare cards with their new Medicare Beneficiary Identifiers (MBIs). MBIs are "non-intelligent" numbers made up of 11 characters of numerals and capital letters. Unlike Railroad Medicare Health Insurance Claim Numbers (HICNs), which could be identified by their format (1-3 letters followed by 6 or 9 numbers), Railroad Medicare MBIs are indistinguishable from other MBIs. With MBIs you will not be able to tell if a patient is eligible for Railroad Medicare just by looking at the number.

The Medicare card of a person with Railroad Medicare will continue to be unique. The Railroad Retirement Board (RRB) will continue issuing Railroad Medicare cards with the RRB logo in the upper left corner, and 'Railroad Retirement Board' at the bottom, as shown here. Railroad Medicare cards will also have a QR code on the front lower right-hand corner of the cards, while Medicare cards will have a QR code on the back of the card. Make sure to ask your patients for their new cards and program your system to identify Railroad Medicare patients based on their cards, if possible.

If you verify your patient's eligibility electronically, CMS will return a message on the eligibility transaction response for a Fee-For-Service (FFS) Railroad Medicare MBI inquiry that will read "Railroad Retirement Medicare Beneficiary" in 271 Loop 2110C, Segment MSG.

If you verify a patient's eligibility using an MBI in the Palmetto GBA eServices online provider portal, the portal will return the "Railroad Retirement Medicare Beneficiary" message in the Additional Information field of the Eligibility sub-tab, as shown below.

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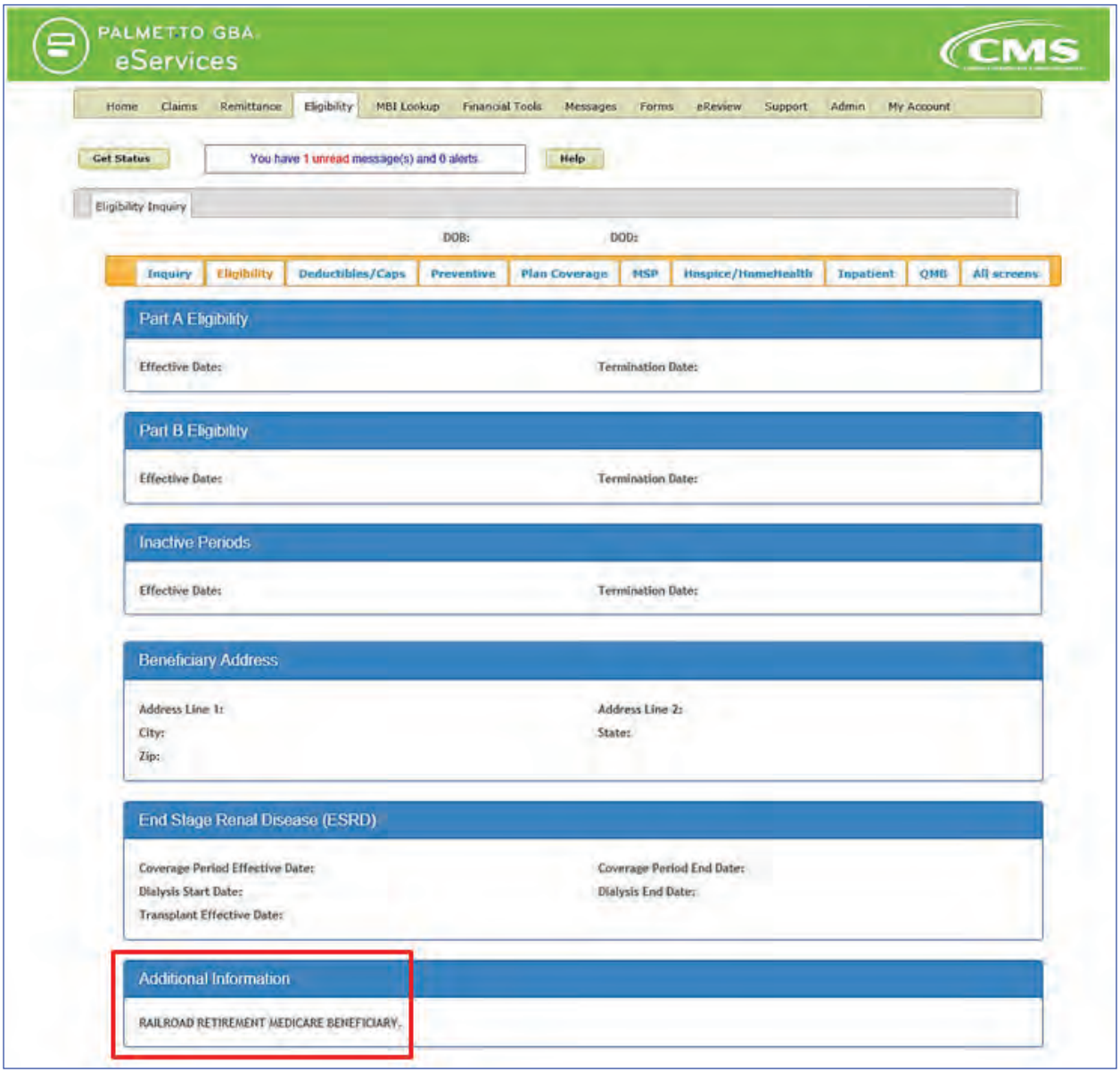

For more information on the new Medicare cards and using the new MBIs, see the following Medicare Learning Network (MLN) resources:

- MBI website: https://www.cms.gov/Medicare/New-Medicare-Card/index
- MLN SE18006 - New Medicare Beneficiary Identifier (MBI) Get It, Use It: https://tinyurl.com/SE18006

Help Us to Help You: Have Your Provider and Patient Information Ready When You Call Customer Service

Having the required provider and beneficiary authentication elements available when you call Customer Service will save you time and help us handle your inquiry more efficiently.

You will be asked for the following information about the provider:

- The provider's National Provider Identifier (NPI)
- The provider's Railroad Medicare Provider Transaction Access Number (PTAN)
- The provider's Tax Identification Number (TIN): last five digits

The Centers for Medicare & Medicaid Services (CMS) requires authentication of these provider elements whenever a request would involve the disclosure of personally-identifiable information (PII) or protected health information (PHI). If you are not able to provide the required elements, our Customer Service Advocates may ask you to obtain the information and call back.

Don't have your Railroad Medicare PTAN? Providers can use our PTAN Lookup and Request Tool to lookup their Railroad Medicare PTAN. If you are employed by a clearinghouse or third-party biller, you must contact the provider to obtain the Railroad Medicare PTAN. See our Using Railroad Medicare's Online PTAN Lookup and Request Tool article for details https://palmettogba.com/Palmetto/Providers.nsf/docsCat/Railroad%20Medicare~Resources~Provider%20Enrollment~Articles~Using%20Railroad%20Medicares%20Online%20PTAN%20Lookup%20and%20Request%20Tool?open&Expand=1

You will be asked to provide the following information about the beneficiary:

- The beneficiary's Medicare Beneficiary Identifier (MBI)
- The beneficiary's last name
- The beneficiary's first name or initial, and either
- The claim date(s) of service (for post-claim inquiries, such as reason for denial or rejection) or
- The beneficiary's date or birth (for pre-claim inquiries, such as entitlement requests/issues)

The CMS requires authentication of these beneficiary elements prior to disclosing PII or PHI about a Medicare beneficiary to an authenticated provider. All information must match. If you are not able to provide the required elements, our Customer Service Advocates may ask you to obtain the information and call back.

Don't have the patient's MBI? There are three ways you and your office staff can get MBIs:

1. Ask your patient
2. Use the MBI Look-up tool on the Palmetto GBA eServices portal or your local Medicare Administrative Contractor's portal
    - You can look up MBIs for your Medicare patients when they don't or can't give them. You must have your patient's first name, last name, date of birth and Social Security Number (SSN) to search. If a patient doesn't want to release their SSN to you, the patient will need to provide you with their MBI.
3. Check a remittance advice
    - If you previously saw a patient and got a claim payment decision based on a claim submission with a HICN before January 1, 2020, look at that remittance advice. We returned the MBI on every remittance

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advice when a provider submitted a claim with a valid and active HICN from October 1, 2018 through December 31, 2019.

Resource: MLN SE18006 — New Medicare Beneficiary Identifier (MBI) Get It, Use It at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18006.pdf

Railroad Medicare's online "PTAN Lookup and Request Tool"

Providers can now obtain their existing Railroad Medicare Provider Transaction Access Number (PTAN) or request a new Railroad Medicare PTAN through our "PTAN Lookup and Request Tool" at http://www.PalmettoGBA.com/RR/PTAN.

Please review the following resources before using the PTAN Tool:

- Using Railroad Medicare's online "PTAN Lookup and Request Tool" https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Railroad%20Medicare~Resources~Provider%20Enrollment~Articles~AK7K447304?open
- Railroad Medicare PTAN Lookup and Request Tool FAQs https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Railroad-Medicare~AXCNMG2662

Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2021

MLN Matters Number: MM12024
Related CR Release Date: November 20, 2020
Related CR Transmitta
l Number: R10469GI
Related Change Request (CR) Number: 12024
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

Provider Types Affected
This MLN Matters Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs for services provided to Medicare beneficiaries.

What You Need To Know
This article informs you of the new Calendar Year (CY) 2021 Medicare premium, coinsurance, and deductible rates.

Background
Beneficiaries who use covered Part A services may be subject to deductible and coinsurance (percent of costs that the enrollee must pay) requirements. A beneficiary is responsible for an inpatient hospital deductible amount which is deducted from the amount payable by the Medicare program to the hospital for inpatient hospital services provided in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per day for the 61st through 90th day spent in the hospital. A beneficiary has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services provided during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30 to 39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10% penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance, which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a

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permanent 10% increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

Policy: 2021 Part A – Hospital Insurance

- **Part A Deductible**
  - $1,484.00
- **Part A Coinsurance**
  - $371.00 a day for days 61 through 90
  - $742.00 a day for days 91 through150 (lifetime reserve days)
  - $185.50 a day for days 21 through 100 (Skilled nursing facility coinsurance)
- **Part A Base Premium (BP)**
  - $471.00 a month
- **Part A BP with 10% surcharge**
  - $518.10 a month
- **Part A BP with 45% reduction**
  - $259.00 a month (for those who have 30 to 39 quarters of coverage)
- **Part A BP with 45% reduction and 10% surcharge**
  - $284.90 a month

2021 Part B – Supplementary Medical Insurance (SMI)

- **Part B Standard Premium**
  - $148.50 a month
- **Part B Deductible**
  - $203.00 a year
- **Pro Rata Data Amount**
  - $145.31 for the 1st month
  - $57.69 for the 2nd month
- **Coinsurance**
  - 20%

Additional Information

The official instruction, CR 12024, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10469gi.pdf. See Attachment A of CR 12024 for Income Parameters for Determining Part B Premium.

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
November 20, 2020	Initial article released.

Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM11957
Related CR Release Date: November 20, 2020
Related CR Transmittal Number: R10473CP
Related Change Request (CR) Number: 11957
Effective Date: April 1, 2021
Implementation Date: April 5, 2021

Provider Types Affected
This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article informs you of updates, as needed, to the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of this update.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.

The codes sets are available on the official ASC X12 website at https://www.x12.org/codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January/February 2021 committee meeting shall be posted on these sites on or about March 1, 2021.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and will be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR11957.

MACs must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. These MACs must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses. They must also use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Healthcare Claim Acknowledgments.

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References in this CR to “277 responses” and “claim status responses” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

Additional Information

The official instruction, CR 11957, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10473cp.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
November 20, 2020	Initial article released.

FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients

MLN Matters Number: SE20024
Article Release Date: December 3, 2020
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This MLN Matters® Special Edition Article is informational in nature. It's intended for all physicians and hospitals that provide Medicare-covered services in the Fee-For-Service (FFS) program.

Provider Action Needed
This article further explains the billing procedures and provides additional resources to avoid incorrect billing for outpatient services within 3 days before date of admission and on the date of admission. This is in response to an Office of Inspector General (OIG) May 2020 report, Medicare Made $11.7 Million in Overpayments for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays (https://oig.hhs.gov/oas/reports/region1/11700508RIB.pdf). Make sure that your billing staffs are aware of this information to avoid billing errors that may lead to overpayments.

Background
In the Calendar Year (CY) 2012 Medicare Physician Fee Schedule (MPFS) final rule, we, CMS finalized the 3-day payment window for MPFS services, consistent with the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA). We issued manual instructions in CR 7502 on December 21, 2011. Since the publication of these documents, we received several Frequently Asked Questions (FAQs) about the 3-day payment window. For your reference, answers to these FAQs as they relate to MPFS services are as follows.

What Is the 3-Day Payment Window?
Medicare's 3-day (or 1-day) payment window applies to outpatient services that hospitals and hospital wholly owned or wholly operated Part B entities furnish to Medicare beneficiaries. The statute requires that hospitals bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (for example, therapeutic) with the claim for an inpatient stay when services are furnished to a Medicare beneficiary in the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) preceding an inpatient admission in compliance with Section 1886 of the Social Security Act.

How Does Section 102 of PACMBPRA Change the Way a Physicians' Practice, or Any Other Part B Entity That a Hospital Wholly Owns or Wholly Operates, Bills and Receives Payment for Medicare Services Subject to the 3-Day Window?
Section 102 of PACMBPRA significantly broadened the definition of related non-diagnostic services that are subject to the payment window to include any non-diagnostic service that's clinically related to the reason for a patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same.

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PACMBPRA made no changes to application of the 3-day (or 1-day) payment window policy to diagnostic services. Application of the payment window policy to diagnostic services hasn't changed since 1998.

Which Services Does Medicare Consider "Diagnostic"?
As discussed in the "Medicare Benefit Policy Manual", Chapter 6, Section 20.4.1, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf, a service is "diagnostic" if it's an exam or procedure to which you subject the patient, or which you perform on materials derived from a hospital outpatient, to get information to aid in your assessment of a medical condition or to identify a disease.

Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests you give to determine the nature and severity of an ailment or injury.

What Type of Hospital Inpatient Admissions Would Be Subject to a 1-Day Payment Window?
The hospital and hospital units subject to the 1-day payment window policy (instead of the 3-day payment window) are:
- Psychiatric hospitals and units
- Inpatient rehabilitation hospitals and units
- Long-term care hospitals
- Children's hospitals
- Cancer hospitals

A wholly owned or wholly operated physician practice (or other Part B entity) of the aforementioned hospitals would also be subject to a 1-day payment window when they furnish diagnostic services and related non-diagnostic services within 1 calendar day preceding an inpatient admission.

Are Critical Access Hospitals (CAHs) Subject to the Payment Window?
If the admitting hospital is a CAH, the payment window policy doesn't apply. However, if the admitting hospital is a short stay acute hospital paid under the inpatient prospective payment system (IPPS) and the wholly owned or wholly operated outpatient entity is a CAH, the outpatient CAH services are subject to the payment window.

The CAH services are also subject to the payment window if the admitting hospital is a psychiatric hospital, inpatient rehabilitation hospital, long-term care hospital, children's hospital, or cancer hospital.

Does the 3-Day Window (or 1-Day Window) Include the 72 Hours (or 24 Hours) Directly Preceding the Inpatient Hospital Admission?
The 3-day payment window applies to services you provide on the date of admission and the 3 calendar days preceding the date of admission that will include the 72-hour time period that immediately precedes the time of admission but may be longer than 72 hours because it's a calendar day policy.

The 1-day payment window applies to the date of admission and the entire calendar day preceding the date of admission and will include the 24-hour period that immediately preceded the time of admission but may be longer than 24 hours.

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What Type of Information About Medicare's 3-Day (or 1-Day) Payment Window Did CMS Publish in CR7502?

CR7502 provides policy, billing, and claims processing instructions about Medicare's 3-day (or 1-day) payment window policy as it pertains to services furnished by hospital wholly owned or wholly operated physician practices or other Part B entities. These instructions include general background information on the payment window, implementation of the payment window policy in wholly owned or wholly operated entities, the definition of wholly owned and wholly operated entities, and how the payment window affects payment to wholly owned and wholly operated entities. (An MLN Matters® Article related to CR7502 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7502.pdf.)

CR7502 also includes instructions about how you should identify services subject to the 3-day (or 1-day) payment window, how the payment window policy affects payment and billing for surgical services with a global period, and business requirements for Medicare Administrative Contractors (MACs).

Although CR7502 includes a comprehensive and detailed explanation of the 3-day (or 1-day) payment window policy, much of the information (such as definition of a wholly owned or wholly operated hospital and application of the policy to diagnostic services) hasn't changed since 1998 and has been long-standing Medicare payment policy.

Does CR7502 Provide Any Specific Billing Instructions for Hospitals?

No, CR7502 only provides billing instructions for the wholly owned or wholly operated physician practice or other Part B entity that furnish services subject to the 3-day (or 1-day) payment window. We published hospital instructions for the implementation of this provision in CR7142, "Clarification of Payment Window for Outpatient Services treated as Inpatient Services." An MLN Matters® Article related to that CR is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7142.pdf.

How Do I Know If My Physician Practice, Or Other Part B Entity, Meets the Statutory Requirements of Hospital Wholly Owned or Wholly Operated?

We define wholly owned or wholly operated entities in 42 CFR 412.2. "An entity is wholly owned by the hospital if the hospital is the **sole owner** of the entity," and "an entity is wholly operated by a hospital if the hospital has **exclusive** responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity." [Emphasis added] The hospital and associated physician practice or other Part B entity must determine whether the entity is wholly owned or wholly operated.

When Would the 3-Day (or 1-Day) Payment Window Not Apply?

The 3-day (or 1-day) payment window doesn't apply in the circumstances described below:

- If the hospital and the physician office or other Part B entity are both owned by a third party, such as a health system; and
- If the hospital isn't the sole or 100 percent owner of the entity, for example, if the hospital has a financial or administrative partner, or if physicians or other practitioners have an ownership interest in the hospital, physician practice or Part B entity. We provide several examples of arrangements where an entity is not wholly owned or wholly operated by the hospital. (See the February 11, 1998, Federal Register, pages 6866-6867 and the CY 2012 MPFS final rule, published November 28, 2011, pages 73285-73286.)

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Will CMS Make a Determination as to Whether a Specific Entity Meets the Definition of Wholly Owned or Wholly Operated?
Given the multitude of possible business and financial arrangements that may exist between a hospital and a physician practice or other Part B entity, CMS won't make individual determinations as to whether a specific physician practice or other Part B entity is wholly owned or wholly operated by an admitting hospital.

In general, if a hospital has direct ownership or control over another entity's operations, then services that other entity provides are subject to the payment window policy. However, if a third organization owns or operates both the hospital and the entity, then the payment window provision doesn't apply. While we can't anticipate every arrangement scenario or make case by case decisions based upon hypothetical scenarios, we've provided several illustrative examples of how we apply this general policy in the CY 2012 MPFS final rule, published on November 28, 2011. The final rule, 76 FR 73285 -73286, is available at http://www.gpo.gov/fdsys/pkg/FR-2011-11-28/pdf/2011-28597.pdf.

Who Makes the Determination as to Whether a Specific Entity Meets (or Doesn't Meet) the Definition of Wholly Owned or Wholly Operated?
The hospital and its owned or operated physician practice (or other Part B entity) are collectively responsible for determining whether the owned or operated physician practice or other Part B entity meets the definition of hospital wholly owned or hospital wholly operated subject to the payment window policy.

If a Hospital Has Recently Purchased My Physician Practice, Should I Update My Ownership Status with Medicare?
Yes, you must notify Medicare of any change of ownership within 30 days of the change. You may notify us by submitting an 855B Medicare Enrollment Application to your MAC, or you can complete this information on-line in the Provider Enrollment Chain and Ownership System.

What If the Determination of Wholly Owned or Wholly Operated of a Specific Arrangement is Still Unclear (After Review by My Legal Counsel)?
We believe that ownership and operational issues are inherently fact-specific and hospitals and hospital owned and operated entities will best know and understand their individual circumstances and whether the physician practice is subject to the payment window policy. If you determine that you aren't wholly owned or wholly operated and not subject to the payment window policy, we recommend that you maintain documentation to support that determination.

How Will a Wholly Owned or Wholly Operated Entity Know When a Beneficiary Has Been Admitted as a Hospital Inpatient?
The admitting hospital is responsible for notifying the entity of an inpatient admission of a Medicare beneficiary who received services in a wholly owned or wholly operated entity within the 3-day (or 1-day) payment window prior to the inpatient admission.

Do the ICD-10 Diagnosis Codes for the Inpatient Admission and Outpatient Non-Diagnostic Service Need to be an Exact Match to be Considered Related?
No. That is the exact policy that PACMBPRA changed. Before the enactment of PACMBPRA, related non-diagnostic services were those services where there was an exact match on the International Classification

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of Diseases, 10th Revision (ICD-10) diagnosis code between pre-hospitalization services and the inpatient admission. The only change that PACMBPRA made was to expand the definition of "related to" services to "all services that are not diagnostic services unless the hospital demonstrates…that such services are not related… to such admission."

The 3-day payment policy now applies to all non-diagnostic services provided during the payment window unless the hospital attests that the services are clinically unrelated.

Diagnostic services always are subject to the payment window, regardless of whether they're considered clinically related.

Will CMS Furnish a List of Non-Diagnostic Service Codes That They Will Consider "Related to" an Inpatient Admission?
No, we won't develop a definitive list of services that are clinically related to an inpatient admission. As discussed in the CY 2012 MPFS final rule, we believe that the determination of whether an outpatient service is clinically related requires knowledge of the specific clinical circumstances surrounding a patient's inpatient admission and can only be determined on a case by case basis (76 FR 73282).

Who is Responsible for Making the Determination as to Whether a Non-Diagnostic Service is (or Isn't) Related to the Beneficiary's Inpatient Admission?
The hospital that owns the wholly owned or wholly operated physician practice (or other Part B entity) and submits the claim to Medicare for the inpatient admission determines that an outpatient service is clinically related to an inpatient admission when it submits an inpatient claim. Once the hospital makes this determination, the Part B claim for physician fee schedule services must be submitted consistent with the decision the hospital made.

How Does the 3-Day Payment Window Affect Wholly Owned or Wholly Operated Physician Practices (or Other Part B Entities)?
The technical component for **all** diagnostic services and those direct expenses that otherwise would be paid through non-facility practice expense relative value units for non-diagnostic services **related** to the inpatient admission, that a wholly owned or wholly operated entity provides within the payment window, are considered hospital costs and must be included on the hospital's bill for the inpatient stay.

Medicare will pay the wholly owned or wholly operated entity through the MPFS for the Professional Component (PC) for service codes with a Technical/Professional Component (TC/PC) split that are provided within the payment window, and at the facility rate (that's, exclusive of those direct practice expenses that are included in the hospital's charges) for service codes without a TC/PC split.

How Will a Wholly Owned or Wholly Operated Physician Practice or Other Part B Entity Identify Services Subject to the 3-Day (or 1-Day) Payment Window on Their Claims?
Physician practices or other Part B entities should use Modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days or 1 day) to identify HCPCS codes for services subject to the payment window.

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When is the Effective Date for Modifier PD?
Wholly owned or wholly operated entities have the discretion to apply the modifier PD for claims with dates of service on and after January 1, 2012, but **must** have begun using the modifier PD for eligible services in the 3-day (or 1-day) payment window no later than July 1, 2012. Additionally, hospitals and physician practices (or other part B entities) must have coordinated billing procedures for services subject to the 3-day (or 1-day) payment window in place no later than July 1, 2012.

What If the Hospital Determines That Non-Diagnostic Outpatient Service(s) Furnished Within the Payment Window Aren't Related to the Inpatient Admission?
Non-diagnostic preadmission services furnished within the payment window that the hospital determines **aren't** clinically related to an inpatient admission **aren't** subject to the 3-day (or 1-day) payment window policy. As such, don't append the modifier PD to the unrelated non-diagnostic service(s).

Should I Use Condition Code 51 to Identify Unrelated Non-Diagnostic Services Furnished in a Wholly Owned or Wholly Operated Physician Practice (or Other Part B Entity)?
No. Only hospitals should use condition code 51 when they bill separately for unrelated outpatient non-diagnostic service claims. You shouldn't append the modifier PD to an unrelated non-diagnostic service furnished in a wholly owned or wholly operated physician practice (or other Part B entity).

The absence of the modifier PD would serve as the attestation that the hospital that wholly owns or wholly operates the physician practice believes that the non-diagnostic service was unrelated to the hospital admission.

Does CMS Consider All Non-Diagnostic Services Furnished on the Date of Admission to be Related to the Inpatient Admission?
Yes, non-diagnostic services a wholly owned or wholly operated physician practice (or other Part B entity) furnishes on the date of a beneficiary's inpatient admission to the hospital are **always** deemed to be related to the admission. The admitting hospital's wholly owned or wholly operated physician practice (or other Part B entity) should use modifier PD to identify non-diagnostic services they furnished on the date of a beneficiary's admission.

What if a Diagnostic Service is Unrelated to the Inpatient Hospital Admission?
The TC of all diagnostic services furnished by a wholly owned or wholly operated entity to a Medicare beneficiary who is admitted as an inpatient within 3 calendar days are subject to the 3-day payment window policy (or 1 day if applicable).

How Should a Wholly Owned or Wholly Operated Physician Practice Bill for Diagnostic Services Subject to the Payment Window?
The wholly owned or wholly operated physician practice (or other Part B entity) should only bill for the Professional Component of a diagnostic service subject to the 3-day (or 1-day) payment window. They must append modifier -26 and modifier PD to the diagnostic HCPCS code for the service. Please note that this policy has been longstanding and has not changed since 1998.

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Should the Wholly Owned or Wholly Operated Physician Practice Bill for the Technical Component of a Diagnostic Service?
No, the wholly owned or wholly operated physician practice (or other Part B entity) **shouldn't** bill for the TC of a diagnostic service subject to the payment window. The modifier PD doesn't apply to the TC of a diagnostic service. The TC of a diagnostic service (for example, taking the x-ray) subject to the payment window is considered part of the admitting hospitals costs and therefore, included on the bill for the inpatient stay.

Should an Ambulatory Surgical Center (ASC) Use the Modifier PD?
Yes, a wholly owned or wholly operated ASC would use the modifier PD to identify outpatient physician or practitioner services subject to the 3-day (or 1-day) payment window.

If a Wholly Owned or Wholly Operated Physician Practice Furnishes a Related Outpatient Evaluation and Management (E/M) Visit Within the Payment Window, Does the Admitting Hospital Include Any Costs Associated with the Outpatient Visit with the Outpatient Bill?
The wholly owned or wholly operated physician practice would bill the related outpatient E/M visit with modifier PD and the Medicare claims processing contractor would pay the physician practice at the facility rate. Medicare would pay the hospital for the direct practice expense associated with the related outpatient E/M visit through payment for the inpatient admission. Direct practice costs (clinical staff, equipment and supplies) for non-diagnostic services related to the inpatient admission the wholly owned or wholly operated entity provides within the payment window are considered hospital costs and must be included on the hospital's bill for the inpatient stay and on the hospital's cost report.

Should I Use the Modifier PD to Identify Outpatient Physician Practitioner Services, Subject to the Payment Window, That Are Performed in the Hospital?
No, don't use modifier PD for outpatient services subject to the 3-day (or 1-day) payment window that are furnished in the hospital.

For example, don't append the modifier PD to physician and practitioner professional services furnished in the hospital outpatient department (including the emergency department), patients receiving observation services, or other outpatient services furnished in a provider-based department of the hospital.

Use modifier PD only for diagnostic and related non-diagnostic outpatient services paid under the MPFS that are furnished in a wholly owned or wholly operated physician practice (or other Part B entity) of the hospital.

Don't append modifier PD to a claim where the payment window policy applies but the service was provided in a hospital. In other words, use the modifier PD to identify related outpatient services subject to the payment window furnished in the physician's office and not by the physician at the hospital.

Hospitals follow different billing instructions from a wholly owned or wholly operated physician practice (or other Part B entity) for billing outpatient services subject to the 3-day payment window furnished in an outpatient department of the hospital. (Refer to the "Medicare Claims Processing Manual", Chapter 4, Section 10.12 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf for billing instructions for hospitals furnishing outpatient services subject to the payment window policy.)

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Must I Append Modifier PD to Services I Provide to an Inpatient?
No, use the modifier PD only for **outpatient** services you provide in the window prior to an inpatient admission subject to the payment window and that you furnish in a wholly owned or wholly operated physician practice or other Part B entity. Don't apply modifier PD to physician fee schedule claims for services provided after the patient has been admitted as an inpatient to the hospital.

Are Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs) Subject to the 3-Day (or 1-Day) Payment Window Policy?
No, the 3-day (or 1-day) payment window policy **doesn't** apply to RHCs or FQHCs. Medicare pays for RHC and FQHC services through an all-inclusive rate that incorporates payment for all covered items and services and related services and supplies an RHC or FQHC physician or practitioner provides to a beneficiary on a single day.

It's not possible to distinguish within the all-inclusive rate the amount of the payment for any particular patient that represents the professional versus the technical portion. Given that the 3-day payment window policy doesn't include professional services, and that RHCs and FQHCs are paid an all-inclusive rate that includes payment for professional services, RHCs and FQHCs currently **aren't** subject to the 3-day payment window policy.

Do I Append Modifier PD to "Incident To" Services?
Yes, if an admitted inpatient got services at a wholly owned or wholly operated entity prior to his or her admission and some of the services where furnished incident to a physician's or other practitioner's services, you would bill for those services according to the 3-day (or 1-day) payment window policy.

How Does the Presence of the Modifier PD Affect Medicare Payment for Non-Diagnostic Services?
For services without a technical and professional component split, modifier PD triggers the claim system to pay the facility rate without a TC/PC split (for example, outpatient physician's visit). In other words, the presence of modifier PD on professional non-diagnostic service codes instructs the MACs to pay the "facility" payment amount in circumstances where, in the absence of the 3-day (or 1-day) payment window policy, the non-facility payment amount may have otherwise applied.

The lower facility physician fee schedule payment shows that the direct expenses associated with providing the service are now hospital costs and included on the hospital's inpatient bill rather than being paid to the physician.

Should I Append the Modifier PD to Global Surgical Services Furnished Within the Payment Window?
Yes, a patient could have a surgical service furnished in a wholly owned or wholly operated physician office or other Part B entity within the payment window and, due to complications, be admitted as an inpatient within the payment window. In such cases, the physician practice would bill modifier PD with the specific surgical service code performed (for example, a diagnostic colonoscopy).

Would There Be Circumstances in Which the Pre- and Post-Operative Services Included with the Global Surgical Package Are Also Subject to the 3-Day Payment Window Policy?
As indicated in the Medicare Claims Processing Manual, Chapter 12, Section 90.7.1, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf, related surgical procedures a wholly owned or wholly operated physician practice (or other Part B entity) furnishes within the 3-day payment window are subject to the 3-day payment window policy. A surgical service with a global period

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payment would be subject to the 3-day payment window policy, when the wholly owned or wholly operated physician practice (or other Part B entity) furnishes the surgical service **and** the date of the actual outpatient surgical procedure falls within the 3-day payment window.

When Would the Actual Outpatient Surgery and the Pre- and Post-Operative Services Furnished During the Global Surgery Time Frame Not Be Subject to the Payment Window Policy?
If the initial surgical procedure that started the global period is furnished outside the payment window, the 3-day (or when applicable 1-day) payment window makes no change in billing a surgical service with a global period, even if some of the post-operative visits that are included in the surgical package occur in the 3-day payment window.

Should a Wholly Owned or Wholly Operated Physician Practice Bill for Both the Inpatient Surgical Procedure and Initial Related Surgical Procedure Performed in the Wholly Owned or Wholly Operated Physician Office That Started the Global Period Under the 3-Day Payment Window Policy?
The 3-day payment window policy **doesn't** apply to inpatient services. The physician performing the inpatient surgical procedure would bill for the inpatient surgery service code according to normal Medicare rules (for example, no modifier PD). The wholly owned or wholly operated physician practice would bill for the preceding outpatient surgical procedure with the modifier PD if the surgeon was part of the wholly owned or wholly operated physician practice.

What Part B Services Aren't Subject to the 3-Day (or 1-Day) Payment Window?
We've excluded outpatient maintenance dialysis services and ambulance services from the pre-admission services that are subject to the payment window.

Should I Apply the Modifier PD to Outpatient Services Related to the Inpatient Admission When There's No Part A Coverage for the Inpatient Stay?
No, don't apply the modifier PD to related outpatient services when there's no Part A coverage for the inpatient stay. In the event that there's no Part A coverage for the inpatient stay, there's no inpatient service into which outpatient services must be bundled. Therefore, preadmission outpatient diagnostic and related nondiagnostic services furnished within the payment window would not be subject to the 3-day (or 1-day) payment window policy.

Should the Wholly Owned or Wholly Operated Physician Practice (or Other Part B Entity) Modify Its Actual Charge for a Related Non-Diagnostic Service to Accommodate a Facility Payment (Instead of a Non-facility Payment)?
The wholly-owned physician practice should include its actual charge when submitting Part B claims for outpatient services subject to the 3-day (or 1-day) payment window. Medicare doesn't require that the wholly owned physician practice modify its charge structure to accommodate a facility payment (instead of a non-facility payment), although the physician practice may choose to do so.

When Did the 3-Day (or 1-Day) Payment Window Policy Become Effective?
On February 11, 1998, beginning on page 6864 of the Federal Register, CMS published a final rule indicating that the payment window applies to diagnostic and related non-diagnostic outpatient services that are otherwise billable under Part B and doesn't apply to nonhospital services that are generally covered under Part A (such as home health, skilled nursing facility, and hospice). Also, the rule defined an entity as hospital wholly owned

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or hospital wholly operated if a hospital is the sole owner of the entity or has the exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. The 1998 final rule also defined non-diagnostic services as being related to the admission only when there's an exact match between the ICD-10-CM diagnosis code assigned for both the preadmission services and the inpatient stay. The 3-day payment window policy became effective March 13, 1998.

In the Fiscal Year (FY) 2011 IPPS final rule, published August 16, 2010, beginning on page 50346 of the Federal Register, CMS discussed changes to the payment window policy (as required by Section 102 of the PACMBPRA). Effective June 25, 2010, the payment window policy applies to non-diagnostic outpatient services clinically related to the inpatient admission furnished to a Medicare beneficiary by a hospital (or an entity wholly owned or wholly operated by the admitting hospital). The payment window policy for diagnostic services remained unchanged. CMS implemented the changes to the definition of "related to" the inpatient admission on April 4, 2011, via CR7142, Transmittal 796, published October 29, 2010.
Moreover, in the CY 2012 MPFS final rule, published November 28, 2011, beginning on page 73279 of the Federal Register, CMS finalized the payment window policy as required by the PACMBPRA, as it relates to wholly owned or wholly operated physician practices. The implementing manual instructions became effective January 1, 2012, with a compliance date of July 1, 2012.

For More Information
For more information on Medicare's 3-day payment window policy please review:

- **Change Request 7502**, Transmittal 2373, published December 21, 2011, entitled "Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Practices"
(https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2373CP.pdf)
- **Medicare Claims Processing Manual, Publication 100-04, Chapter 12**, Sections 90.7 and 90.7.1
(https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2373CP.pdf)
- **CY 2012 MPFS final rule**, published November 28, 2011 (76 FR 73279-73286)
(https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2373CP.pdf)
- **FAQs for CR7502**
(https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/CR7502-FAQ.pdf)
- MLN Matters® Article **MM7502**: Bundling of Payment for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Offices
(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7502.pdf)
- Physician Fee Schedule Page
(https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index?redirect=/PhysicianFeeSched/)
and
- Hospital Prospective Payment System Page
(https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Three_Day_Payment_Window)

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Additional Information

You may want to review the following documents:

- The fast facts at

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Fast-Facts

- OIG Report #A-01-17-00508 (Medicare Made $11.7 Million in Overpayments for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays)

(https://oig.hhs.gov/oas/reports/region1/11700508.pdf)

- MLN Article SE1324

(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1324.pdf)

(Pre-admission Diagnostic Testing Review)

- MLN Article SE17033

(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE17033.pdf)

(Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities)

If you have questions, contact your MAC (https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List).

Document History

Date of Change	Description
December 3, 2020	Initial article released.

CY 2021 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: MM12063
Related CR Release Date: December 4, 2020
Related CR Transmittal Number: R10504CP
Related Change Request (CR) Number: 12063
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

Provider Types Affected
This MLN Matters® Article is for providers and suppliers submitting claims to MACs for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule provided to Medicare beneficiaries.

Provider Action Needed
This article provides the Calendar Year (CY) 2021 annual update for the Medicare DMEPOS fee schedule. The article includes information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background
We (CMS) update the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. Payment on a fee schedule basis is required for certain DMEPOS and surgical dressings by Sections 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts, and Intraocular Lenses (IOLs) inserted in a physician's office. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to fee schedule adjustments using information on the payment determined for these items under the DMEPOS Competitive Bidding Program (CBP), as well as codes that are not subject to the CBP or fee schedule adjustments.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for DME items included in the CBP for payment of the items in areas that are not Competitive Bidding Areas (CBAs). Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. The methodologies for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR Section 414.210(g).

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, 2020
Additional information on Section 3712 of the CARES Act is available in Transmittal 10016, CR 11784, of May 8, 2020. The related MLN Matters article (MM11784) is available at https://www.cms.gov/files/document/mm11784.pdf.

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The Interim Final Rule with Comment (IFC) period (CMS-5531-IFC) titled, The Medicare and Medicaid Programs, Basic Health Program and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program, was published in the Federal Register on Friday, May 8, 2020. The IFC implements Section 3712 of the CARES Act, which was signed into law on March 27, 2020. Sections 3712(a) and (b) of the CARES Act, respectively, require the following:

- For items and services subject to the fee schedule adjustments furnished in rural or non-contiguous areas, the fee schedule amounts will continue to be based on a blend of 50% of the adjusted fee schedule amounts and 50% of the unadjusted fee schedule amounts (that is, no change from the current fee schedule amounts) through December 31, 2020, or the duration of the COVID-19 Public Health Emergency (PHE), whichever is later.
- For items and services subject to the fee schedule adjustments furnished in non-rural contiguous non-CBAs, the fee schedule amounts will be based on a blend of 75% of the adjusted fee schedule amounts and 25% of the unadjusted fee schedule amounts (that is, an increase in the fee schedule amounts) for claims with dates of service beginning March 6, 2020, and continuing until the end of the COVID-19 PHE.

As the PHE continues, the 2021 DMEPOS and PEN fee schedule update files continue to include the rural and non-contiguous non-CBA 50/50 blended fees and the non-rural contiguous non-CBA 75/25 blended fees required by Section 3712 of the CARES Act.

For the 2021 fee schedule update, the following fee schedule adjustment methodologies apply in non-CBAs based on the areas in which the suppliers furnish items and services:

1. Fee Schedule Amounts for Areas within the Contiguous United States

In accordance with the CARES Act and 42 CFR 414.210(g)(9)(iii) (https://www.ecfr.gov/cgi-bin/text-idx?SID=f2ad29d47d84a84e706186de37f5fefb&mc=true&node=se42.3.414_1210&rgn=div8), the adjusted fee schedule amounts for items furnished in non-competitively bid rural areas are based on a blend of 50% of the adjusted fee schedule amount and 50% of the unadjusted fee schedule amount for the item, which is updated by the covered item updates specified in Sections 1834(a)(14), 1834(h)(4), and 1842(s)(B) of the Act, for DME, orthotics, and enteral nutrition respectively. Per the CARES Act and Section 414.210(g)(v), the adjusted fee schedule amounts for items furnished in non-competitively bid non-rural areas are based on a blend of 75% of the adjusted fee schedule amount and 25% of the unadjusted fee schedule amount for the item, which is updated by the covered item updates specified in Sections 1834(a)(14), 1834(h)(4), and 1842(s)(B) of the Act, for DME, orthotics, and enteral nutrition respectively.

To determine the adjusted fee schedule amounts, we use the average of the Single Payment Amounts (SPAs) from CBAs located in eight different regions of the contiguous United States to adjust the fee schedule amounts for the states located in each of the eight regions. These Regional SPAs (RSPAs) are also subject to a national ceiling (110% of the average of the RSPAs for all contiguous states plus the Washington, D.C.) and a national floor (90% of the average of the RSPAs for all contiguous states plus D.C.). This method applies to competitively bid items furnished in the contiguous United States (those included in more than 10 CBAs). Fee schedule amounts for competitively bid items included in 10 or fewer CBAs are adjusted so that they are equal to 110% of the average of the SPAs for the 10 or fewer CBAs.

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ZIP codes associated with the address used for pricing a DMEPOS claim determine the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. The DMEPOS Rural ZIP code file contains the ZIP codes designated as rural areas. ZIP codes for non-continental Metropolitan Statistical Areas (MSAs) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary. Regulations at 42 CFR 414.202 (https://www.ecfr.gov/cgi-bin/text-idx?SID=f2ad29d47d84a84e706186de37f5fefb&mc=true&node=se42.3.414_1202&rgn=div8) define a rural area to be a geographical area represented by a postal ZIP code where at least 50% of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also includes any ZIP Code within an MSA that is excluded from a CBA established for that MSA.

2. Fee Schedule Amounts for Areas outside the Contiguous United States

In accordance with the CARES Act and 42 CFR 414.210(g)(9)(iii), fee schedule amounts for items furnished in areas outside the contiguous United States (such as Alaska, Guam, and Hawaii) are based on a blend of 50% of the adjusted fee schedule amount and 50% of the unadjusted fee schedule amounts updated by the covered item updates specified in Sections 1834(a)(14), 1834(h)(4) and 1842(s)(B) of the Act. Areas outside the contiguous United States receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

3. Fee Schedule Amounts for Items Where Contracts Were Not Awarded in Round 2021 of the CBP in CBAs and Former CBAs

Round 2021 of the DMEPOS CBP begins on January 1, 2021, and extends through December 31, 2023. On October 27, 2020, CMS announced that it will only award Round 2021 CBP contracts to bidders in the off-the-shelf back and knee brace product categories (see https://www.cms.gov/files/document/round-2021-dmepos-cbp-single-payment-amts-fact-sheet.pdf). We will not award Round 2021 CBP contracts to bidders that bid in any of the other 13 product categories that were included in Round 2021 of the CBP. Also, in 3 of the 130 CBAs, we will award no contracts for Round 2021 and these areas (Colorado Springs, Colo., Miami-Fort Lauderdale-West Palm Beach, Fla., and Worcester, Mass.) will remain as former CBAs during this round.

For items that we included in Round 2021 but where contracts haven't been awarded in Round 2021 of the CBP, pursuant to 42 CFR 414.210(g)(10), we base the fee schedules for these items and services furnished in CBAs on the SPAs in effect in the CBA on the last day before the CBP contract period of performance ended (that is, December 31, 2018), increased by the projected percentage change in the Consumer Price Index for All Urban Consumers (CPI-U) for the 12-month period on the date after the contract periods ended. Fee schedule amounts are increased once every 12 months on the anniversary date of the first day after the contract period ended with the CPI-U.

For CY 2019, the fee schedule amounts for these items were adjusted based on the SPAs for each specific CBA, increased by the projected percentage change in the CPI-U of 2.5% for the 12-month period ending January 1, 2019. For CY 2020, the adjusted fee schedule amounts were increased by the projected change in the CPI-U of 2.4%. For 2021, the 2020 adjusted fee schedule amounts are increased by the projected percentage change in the CPI-U of 0.6% for the 12-month period ending January 1, 2021.

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KE Modifier
As the revised fee schedule amounts are based in part on unadjusted fee schedule amounts, the January 2021 DMEPOS fee schedule files will also continue to incorporate fee schedule amounts for certain codes billed in conjunction with modifier KE for all non-CBA areas. Background information on the KE modifier is in Transmittal 1630, CR 6270. (See related article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6270.pdf.) In cases where accessories included in the Initial Round One CBP in 2008 are furnished for use with base equipment that was not included in the 2008 CBP (for example, manual wheelchairs where the KU modifier does not apply, canes, and aspirators), for beneficiaries residing in non-rural areas, suppliers should append the KE modifier to the HCPCS code for the accessory.

KU Modifier
The Further Consolidated Appropriations (FCA) Act, 2020 (Pub. L. 116-94) was signed into law on December 20, 2019. Section 106 of the FCA Act mandates that, during the period beginning on January 1, 2020, and ending June 30, 2021, adjustments to the Medicare fee schedule amounts for certain DME based on information from CBPs not be applied to wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with complex rehabilitative manual wheelchairs (HCPCS codes E1161, E1231, E1232, E1233, E1234 and K0005) and certain manual wheelchairs currently described by HCPCS codes E1235, E1236, E1237, E1238, and K0008).

As a result, KU modifier fees for wheelchair accessory and seat and back cushion HCPCS codes impacted by this change continue to be included in the DMEPOS fee schedule file and are effective for dates of service through June 30, 2021. The fees for items denoted with the HCPCS modifier KU represent the unadjusted fee schedule amounts (the CY 2015 fee schedule amount updated to the present CY by the DMEPOS covered item updates). Additional instructions, as well as the applicable complex rehabilitative and certain manual wheelchair accessory codes associated with this provision are listed in Transmittal 10019, CR 11635, dated May 7, 2020, and available at https://www.cms.gov/files/document/r10019otn.pdf.

Public Use Files (PUFs)
The following 2021 DMEPOS fee schedule and ZIP code PUFs will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the above files on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html. These include:
1. DMEPOS Fee schedule PUF
2. DME PEN Fee schedule PUF
3. DMEPOS Rural ZIP code PUF
4. Former CBA Fee schedule PUF
5. Former CBA National Mail Order diabetic testing supply fee schedule PUF
6. Former CBA ZIP Code PUF

Beginning January 1, 2021, the former CBA ZIP code file will contain the CBA ZIP codes for the items in the 13 product categories where contracts were not awarded in from Round 2021 of the CBP. We will update this ZIP file on a quarterly basis as necessary.

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2021 Fee Schedule Update Factor of 0.2%
For CY 2021, an update factor of 0.2% is applied to certain DMEPOS fee schedule amounts. Fee schedule amounts that are adjusted using information from CBPs are not subject to the annual DMEPOS covered item update but will be updated pursuant to the applicable adjustment methodologies outlined in 42 CFR 414.210(g).

In accordance with Section 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2021 by the percentage increase in the Consumer Price Index for all CPI-U for the 12-month period ending June 30, 2020, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The MFP adjustment is 0.4% and the CPI-U percentage increase is 0.6%. Thus, the 0.6% increase in the CPI-U is reduced by the 0.4% increase in the MFP resulting in a net increase of 0.2% for the update factor.

New Codes Added
There are no DMEPOS codes added to the HCPCS file, effective January 1, 2021.

For gap-filling pricing purposes, the deflation factors for 2020 by payment category are:
- 0.425 for Oxygen
- 0.427 for Capped Rental
- 0.429 for Prosthetics and Orthotics
- 0.544 for Surgical Dressings
- 0.592 for Parental and Enteral Nutrition
- 0.891 for Intraocular Lenses
- 0.906 for Splints and Casts

You'll find instructions for Gap-filling DMEPOS fees are available in Chapter 23, Section 60.3 of the Medicare Claims Processing Manual (Pub. 100-04), which is part of CR 12063.

Codes Deleted
There are no HCPCS codes deleted from the DMEPOS fee schedule files effective January 1, 2021.

2021 Oxygen and Oxygen Equipment Fee Schedule Amounts
Per Section 1834(a)(9)(D)(ii) of the Act, we apply a budget neutrality offset to all oxygen payment classes and items including:
- Stationary oxygen equipment and oxygen contents (E0424, E0439, E1390, and E1391)
- Portable oxygen equipment add-on (E0431 and E0434)
- Oxygen generating portable equipment add-on (E0433, E1392, and K0738)
- Stationary contents (E0441 and E0442)
- Portable contents (E0443 and E0444)
- Portable liquid contents for high-flow patients (E0447)

For CY 2021, the offset percentage is a reduction and varies by geographic area and is about 5% in non-CBA areas and about 9 percent in CBA areas. Because oxygen and oxygen equipment furnished in CBAs are not included in the Round 2021 CBP, these oxygen and oxygen equipment fees will receive an update of 0.6 percent (CPI-U) that when combined with the statutorily required budget neutrality offset, on average, will be 0.7

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percent reduction, such that the net result, in most cases will be a slight decrease to the oxygen fees for 2021. Similarly, in non-CBAs, the oxygen offset percentage may exceed the annual updates applied to the blended amounts resulting in a reduction in oxygen fees for 2021. For context, the reduction in oxygen fees will be no more than 23 cents in CBAs and in non-CBAs.

Therapeutic Shoe Modification Codes

We are adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect most current allowed service data. Section 1833(o)(2)(C) of the Act require payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512, A5513, and A5514). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2021, we are updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512, A5513, and A5514 will be weighted based on the approximated total allowed services for each code for items furnished during CY 2019. We are revising the fee schedule amounts for shoe modification codes A5503 through A5507 to reflect this change, effective January 1, 2021.

Diabetic Testing Supplies (DTS)

The fee schedule amounts for non-mail order DTS (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are not updated by the annual covered item update. Per Section 1834(a)(1)(H) of the Act, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the SPAs for mail-order DTS established in implementing the national mail order CBP under Section 1847 of the Act. Initial program instructions on these fees are available in Transmittal 2709, CR 8325 (a related article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8325.pdf) and Transmittal 2661, CR 8204. A related article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf.

The National Mail-Order Recompete DTS SPAs are available at http://www.dmecompetitivebid.com/cbic/cbic.nsf/DocsCat/Home.

The non-mail order DTS amounts on the fee schedule will be updated each time the single payment amounts are updated. This can happen no less often than every time the mail order CBP contracts are re-competed.

The National Mail Order Recompete CBP for mail-order diabetic supplies was effective July 1, 2016, to December 31, 2018. As of January 1, 2021, payment for non-mail order diabetic supplies at the National Mail-Order Recompete SPAs will continue in accordance with Section 1834(a)(1)(H) of the Act and these rates will remain in effect until new SPA rates are established under the national mail-order program.

Effective January 1, 2021, the fee schedule amounts for mail-order DTS (with KL modifier) are adjusted using the methodology for areas that were formerly CBAs during periods when there is a temporary lapse in the

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CBP. The National Mail-Order Recompete DTS SPAs of December 31, 2018, are increased by the projected percentage change in the CPI-U for the 12-month period on the date after the contract periods ended.

We increase the fee schedule amounts once every 12 months on the anniversary date of the first day after the contract period ended with the CPI-U. For dates of service between January 1, 2019, and December 31, 2019, the National Mail-Order Recompete SPAs are updated by the projected change of 2.5%. For CY 2020, the adjusted CY 2019 mail-order DTS fees are updated by the projected percentage change in the CPI-U of 2.4% for the 12-month period ending January 1, 2020. For CY 2021, the adjusted CY 2020 mail-order DTS fees are updated by the projected percentage change in the CPI-U of 0.6% for the 12-month period ending January 1, 2021.

The national mail order adjusted fee schedule amounts will be used in paying mail-order diabetic testing supply claims throughout the United States, as well as Washington D.C., Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

2021 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

We updated for 2021 the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR 6792 (a related article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf) and Transmittal 717, CR 6990. A related article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm6990.pdf.

Payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or the end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR 414.210(e)(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10% of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act.

Thus, the 2020 maintenance and servicing fee is adjusted by the 0.2% MFP-adjusted covered item update factor to yield a CY 2020 maintenance and servicing fee of $73.17 for oxygen concentrators and transfilling equipment.

2021 Labor Payment Amounts for Repairs & Service Codes

Attachment A on page 14 of CR 12063 (https://www.cms.gov/files/document/r10504cp.pdf)lists the CY 2021 allowed payment amounts for HCPCS labor payment codes:

- K0739 Repair or non-routine service for Durable Medical Equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes
- L4205 Repair of orthotic device, labor component, per 15 minutes
- L7520 Repair prosthetic device, labor component, per 15 minutes

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Since the percentage increase in the CPI-U for the 12-month period ending with June 30, 2020, is 0.6%, we applied this change to the 2020 labor payment amounts to update the rates for CY 2021. The 2021 labor payment amounts are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2021, through December 31, 2021.

Additional Information

The official instruction, CR 12063, issued to your MAC regarding this change, is available at https://www.cms.gov/files/document/r10504cp.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
December 7, 2020	Initial article released.

Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

MLN Matters Number: MM11943
Related CR Release Date: November 20, 2020
Related CR Transmittal Number: R10472CP
Related Change Request (CR) Number: 11943
Effective Date: April 1, 2021
Implementation: April 5, 2021

Provider Types Affected
This MLN Matters Article is for physicians, hospitals, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the Medicare's system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure billing staffs are aware of these updates. If you use the MREP or PC Print software, be sure to get the updated software.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule published three times per year around March 1, July 1, and November 1.

CR 11943 is a code update notification that indicates when updates to CARC and RARC lists are available on the official Accredited Standards Committee (ASC) X12 website. Medicare's Shared System Maintainers (SSMs) are responsible for implementing code deactivation; making sure that any deactivated code is not included in original business messages and allowing the deactivated code in derivative messages. The SSMs make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the official ASC X12 website. If any new or modified code has an effective date later than the implementation date specified in CR 11943, MACs must implement on the date specified on the official ASC X12 website at https://nex12.org/index.php/codes

A discrepancy between the dates may arise, as the official ASC X12 website updates only three times per year and may not match the CMS release schedule. For CR 11943, the MACs and the SSMs must get the complete

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list for both CARCs and RARCs from the official ASC X12 website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update required by CR 11708. An article related to that CR is at https://www.cms.gov/files/document/mm11708.pdf.

Additional Information

The official instruction, CR 11943, issued to your MAC regarding this change, is available at https://www.cms.gov/files/document/r10472cp.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
November 20, 2020	Initial article released.

Implement Operating Rules – Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule – Update from Council for Affordable Quality Healthcare (CAQH) CORE

MLN Matters Number: MM11988
Related CR Release Date: November 20, 2020
Related CR Transmittal Number: R10474CP
Related Change Request (CR) Number: 11988
Effective Date: April 1, 2021
Implementation Date: April 5, 2021

Provider Types Affected
This MLN Matters Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article informs you of Medicare system updates based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform use of Claims Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Claim Adjustment Reason Code (CAGC) rule publications. These system updates are based on the CORE Code Combination List to be published on or about February 1, 2021. Please make sure your billing staffs are aware of these updates.

Background
The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection sections in 45 Code of Federal Regulations (CFR) 162.1601-162.1603 and Section 1104 of the Affordable Care Act of 2010.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act (the Act) by adding Part C – Administrative Simplification – to Title XI of the Act. Part C requires the Secretary of HHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and create more uniformity in the implementation of standard transactions. Meeting these goals would achieve cost reduction and efficiency improvements. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

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CF 11988 deals with the regular update in CAQH CORE-defined code combinations per Operating Rule 360 – Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2021. This is based on the CARC and RARC updates as posted at the official ASC X12 website on or about November 1, 2020. This will also include updates based on the market-based review that CAQH CORE conducts once every 2 years to accommodate code combinations that are currently being used by health plans, including Medicare, as the industry requires.

See the official ASC X12 website for CARC and RARC updates, as well as CAQH CORE-defined code combination update at http://www.caqh.org/sites/default/files/core/phase-iii/code-combinations/CORE-required_CodeCombos.xlsx?token=_29xvBua.

All health plans (including Medicare) must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE-developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE-defined business scenarios. Within those CORE-defined business scenarios, however, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information

The official instruction, CR 11988, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10474cp.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
November 20, 2020	Initial article released.

Summary of Policies in the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

MLN Matters Number: MM12071
Related CR Release Date: December 4, 2020
Related CR Transmittal Number: R10505CP
Related Change Request (CR) Number: 12071
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

Provider Types Affected
This MLN Matters Article is for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services Medicare pays using the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed
CR 12071 provides a summary of the policies in the Calendar Year (CY) 2021 MPFS Final Rule and makes other policy changes that apply to Medicare Part B. These changes are effective January 1, 2021, and applicable to services you provide throughout CY 2021. Make sure your billing staffs are aware of these updates.

Background
Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish, by regulation, a fee schedule of payment amounts for physicians' services for the subsequent year.

We (CMS) issued a final rule that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2021.The final rule also addresses public comments on Medicare payment policies proposed earlier this year. You'll find the final rule at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFSFederal-Regulation-Notices-Items/CMS-1734-F.html.

The CY 2021 changes are:

Medicare Telehealth Services
We are finalizing the proposal to add several HCPCS codes to the list of telehealth services on a permanent basis. We are also finalizing the proposal to add additional HCPCS codes to the list of telehealth services on a temporary basis until the end of the CY in which the Public Health Emergency (PHE) for COVID-19 ends or December 31, 2021. The list of codes we added to the telehealth services list are at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

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Telehealth Origination Site Facility Fee Payment Amount Update
Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent CY, Medicare increases the telehealth originating site facility fee by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act.

The MEI increase for 2021 is 1.4%. For CY 2021, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge, or $27.02 (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

Remote Physiologic Monitoring (RPM)
In response to stakeholder questions about RPM, in the CY 2021 MPFS final rule CMS clarified payment policies related to the RPM services described by Current Procedural Terminology (CPT) codes 99453, 99454, 99091, 99457, and 99458. Also, we finalized as permanent policy two modifications to RPM services that were finalized in response to the PHE for COVID-19.

These two policies include allowing you to obtain consent when you furnish RPM services and allowing auxiliary personnel to furnish CPT codes 99453 and 99454 services under a physician's supervision. Specific clarifications related to payment policies are in the Care Management section of the MPFS final rule.

Item for Regulatory Action Regarding Scope of Practice: Supervision of Diagnostic Tests
We are finalizing the proposed policy regarding supervision of diagnostic tests by certain Non-Physician Practitioners (NPPs) with a modification to include Certified Registered Nurse Anesthetists (CRNAs) to the list of NPPs who are eligible under the Medicare Part B program to supervise the performance of diagnostic tests under applicable State law and scope of practice.

While physicians (medical doctors and doctors of osteopathy) were previously the only professionals authorized under Federal regulations at 42 CFR 410.32 to supervise the performance of diagnostic tests; Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Physician Assistants (PAs), Certified Nurse-Midwives (CNMs) and CRNAs are now also eligible to supervise the performance of diagnostic tests providing the tests fall under applicable state laws and scope of practice. Also, these NPPs must meet the supervision requirements under Medicare regulations that govern their respective statutory benefit category.

Medical Record Documentation
In the CY 2020 MPFS final rule, we finalized broad modifications to the medical record documentation requirements for the physician and certain NPPs.
The 2021 finalized rule clarifies that:

- Physicians and NPPs, including therapists, can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the MPFS
- Therapy students, and students of other disciplines, working under a physician or practitioner who furnishes and bills directly for their professional services to the Medicare program, may document in the record so long as it is reviewed and verified (signed and dated) by the billing physician, practitioner, or therapist.

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Therapy Assistants Furnishing Maintenance Therapy

We are finalizing the part B policy for maintenance therapy services that was adopted on an interim basis for the PHE for COVID-19 in the May 1st COVID-19 Interim Final Rule with Comment Period (IFC).

This finalized policy allows:

- Physical Therapists (PT) and Occupational Therapists (OT) to delegate the furnishing of maintenance therapy services, as clinically appropriate, to a Physical Therapy Assistant (PTA) or an Occupational Therapy Assistant (OTA)
- PTs/OTs to use the same discretion to delegate maintenance therapy services to PTAs/OTAs that they use for rehabilitative services.

Pharmacists Providing Services Incident To Physicians' Services

We are finalizing the clarification provided in the May 8th COVID-19 IFC (85 FR 27550 through 27629) (https://www.ecfr.gov/cgi-bin/text-idx?SID=f2ad29d47d84a84e706186de37f5fefb&mc=true&node=se42.3.414_1202&rgn=div8) that pharmacists fall within the regulatory definition of auxiliary personnel under CMS regulations at 42 CFR Section 410.26. As such, pharmacists may provide services incident to the services, and under the appropriate level of supervision of the billing physician or NPP, if payment for the services isn't made under the Medicare Part D benefit.

This includes providing the services incident to the services of the billing physician or NPP and in accordance with the pharmacist's state scope of practice and applicable state law. However, physicians and other reporting practitioners can't use Evaluation and Management (E/M) visit codes other than CPT code 99211 to report such services as part of an E/M visit, because those E/M visit codes primarily describe work performed by individuals qualified to directly report the service.

Application of Teaching Physician Regulations

In the 2021 Notice of Proposed Rulemaking (NPRM), CMS solicited public comments on whether the policies implemented on an interim basis in the March 31st and May 8th COVID-19 IFCs should be terminated, temporarily extended through the end of the PHE for COVID-19, or made permanent.

- For residency training sites of a teaching setting that are outside of a Metropolitan Statistical Area (MSA), we are finalizing the proposal to permanently implement the policy, for CY 2021, allowing teaching physicians to use audio/video real-time communications technology to interact with the resident through virtual means in order to meet the requirement that they be present for the key portion of the service; including when the teaching physician involves the resident in furnishing Medicare telehealth services.
- For residency training sites of a teaching setting that are outside of an MSA, we are finalizing the proposal to permanently implement the policy allowing teaching physicians involving residents in providing care at primary care centers to provide the necessary direction, management and review for the resident's services using audio/video real-time communications technology for CY2021.
- Within these sites, residents furnishing services at primary care centers may furnish an expanded set of services to beneficiaries, including level 4 of an office/outpatient E/M visit, transitional care management, and communication technology-based services.

These flexibilities don't apply in the case of surgical, high-risk, interventional, other complex procedures, or services performed through an endoscope and anesthesia services.

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In order to ensure that the teaching physician renders the patient sufficient personal and identifiable physicians' services; and exercises full, personal control over the management of the portion of the case for which the payment is sought; the documentation in the medical record must clearly reflect how the teaching physician was present to the resident during the key portion of the service. This is in accordance with Section 1842(b)(7)(A)(i)(I) of the Act.

For example, in the medical record, the teaching physician could document their physical or virtual presence during the key portion of the service.

Resident Moonlighting

In the 2021 NPRM, we asked for public comments on whether the moonlighting policy implemented on an interim basis in the March 31st COVID-19 IFC should be terminated, temporarily extended through the end of the PHE for COVID-19, or made permanent.

We are finalizing the proposal to permanently expand the settings in which residents may moonlight to include the services of residents that aren't related to their approved Graduate Medical Education (GME) programs and which are furnished to inpatients of a hospital in which they have their training program for CY2021.

To prevent the potential duplication of payment with the Inpatient Prospective Payment System for GME, the full documentation in the medical record must show that the resident:

- Furnished identifiable physician services that meet the conditions of payment of physician services to beneficiaries in 42 CFR Section 415.102(a),
- Is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed
- Didn't perform these services as part of the approved GME program.

Office/Outpatient E/M Visits

Effective January 1, 2021, we are implementing new coding, prefatory language, and interpretive guidance framework that the American Medical Association Current Procedural Terminology Editorial Panel issued for office/outpatient E/M visits.

Under this new CPT coding framework, history and exam will no longer be used to select the level of code for office/outpatient E/M visits. Instead, an office/outpatient E/M visit will include a medically appropriate history and exam, when performed. The clinically outdated system for number of body systems/areas reviewed and examined under history and review will no longer apply, and the history and exam components will be performed when they are reasonable and necessary, and clinically appropriate.

The changes will include deletion of CPT code 99201 *(Level 1 office/outpatient E/M visit, new patient)*. For levels 2 through 5 office/outpatient E/M visits, selection of the code level to report will be based on either the level of medical decision making (as redefined in the new AMA/CPT guidance framework), or the total time personally spent by the reporting practitioner on the day of the visit (including time with and without direct patient contact).

For office/outpatient E/M visits, the 1995 and 1997 E/M guidelines will no longer be used. For further guidance, see https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management.

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Prolonged Office/Outpatient E/M Visits

We are finalizing HCPCS code G2212 for prolonged office/outpatient E/M visits. G2212 is to be used for billing the MPFS instead of CPT code 99358, 99359 or 99417, with the following descriptor: "Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416) (Do not report G2212 for any time unit less than 15 minutes)."

Please see the table, below, which displays the required times for reporting prolonged office/outpatient E/M visits for new and established patients. When the reporting practitioner's time is used to select the office/outpatient E/M visit level, HCPCS code G2212 could be reported when the maximum time for the level 5 office/outpatient E/M visit is exceeded by (at least) 15 minutes on the date of the service.

Prolonged Office/Outpatient E/M Visit Reporting New Patient

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99205 x 1 and G2212 x 3 or more for each additional 15 minutes.	119 or more

*Total time is the sum of all time, with and without direct patient contact (including prolonged time), spent by the reporting practitioner on the date of service of the visit.

Proposed Prolonged Office/Outpatient E/M Visit Reporting Established Patient

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84- 98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes.	99 or more

*Total time is the sum of all time, with and without direct patient contact (including prolonged time), spent by the reporting practitioner on the date of service of the visit.

NOTE: Physicians will use the prolonged preventive services G0513 and G0514 as an add-on to the covered preventive services that you'll find at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html.

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Office/Outpatient E/M Visit Complexity Add-On

Beginning in 2021, there will be a new, Medicare-specific add-on code to report office/outpatient E/M visit complexity. This HCPCS code is G2211: "Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)."

This code reflects the time, intensity, and practice expense when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. This includes furnishing patients' ongoing services that result in a comprehensive, longitudinal, and continuous relationship with the patient and involves delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

For example, in the context of primary care, HCPCS add-on code G2211 could recognize the resources inherent in holistic, patient-centered care that integrates the treatment of illness or injury, management of acute and chronic health conditions, and coordination of specialty care in a collaborative relationship with the clinical care team. In the context of specialty care, HCPCS add-on code G2211 could recognize the resources inherent in engaging the patient in a continuous and active collaborative plan of care related to an identified health condition the management of which requires the direction of a clinician with specialized clinical knowledge, skill and experience.

Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals. In both examples, HCPCS add-on code G2211 reflects the time, intensity, and Practice Expense (PE) associated with providing services that result in care that is personalized to the patient. We aren't restricting billing based on specialty but do assume that certain specialties furnish these types of visits more than others.

Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

We are finalizing:

- The proposal to extend the definition of OUD treatment services to include opioid antagonist medications, such as naloxone, that are approved by FDA under Section 505 of the United States Federal Food, Drug, and Cosmetic Act for emergency treatment of opioid overdose.
- The proposed creation of a new add-on code to cover the cost of providing patients with nasal naloxone and pricing this code based upon the methodology set forth in section 1847A of the Act, except that the payment amount shall be Average Sales Price (ASP) + 0.
- Since auto-injector naloxone is no longer available in the marketplace, we are instead finalizing a second new add-on code to cover the cost of providing patients with injectable naloxone and is contractor pricing this code for CY 2021.
- The proposal to apply a frequency limit on the codes describing naloxone, but is allowing exceptions in the case where the beneficiary overdoses and uses the supply of naloxone given to them by the OTP, to the extent that it is medically reasonable and necessary.

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- The proposal to allow periodic assessments to be furnished via two-way interactive audio-video communication technology.

Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule

In the CY 2020 PFS final rule (84 FR 63102 through 63104), we finalized the creation of two new HCPCS codes, G2082 and G2083 (effective January 1, 2020) on an interim final basis to allow for payment under the MPFS for use of esketamine in services to patients with treatment-resistant depression.

After consideration of public comments, for CY 2021, we are finalizing the proposal to refine the values for HCPCS codes G2082 and G2083 using a building block methodology that sums the values associated with several codes.

Insertion, Removal, and Removal and Insertion of Implantable Interstitial Glucose Sensor System (Category III CPT codes 0446T, 0447T, and 0448T)

Category III CPT codes 0446T, 0447T, and 0448T describe services related to the insertion and removal of an implantable interstitial glucose sensor system, which are currently contractor priced. Given the immediate needs of Medicare beneficiaries with diabetes, including some who could benefit from the use of innovative technologies, in the CY 2020 PFS final rule (84 FR 62627), we requested information from stakeholders to ensure proper payment for this important physician's service for the insertion, removal, and removal and insertion of implantable interstitial glucose sensor system and welcomed recommendations on appropriate valuation for these services to be considered in future rulemaking.

After consideration of public comments, for CY 2021, we are finalizing the work Relative Value Units as proposed for Category III CPT codes 0446T, 0447T, and 0448T, and finalizing the direct PE inputs as proposed aside from removing the equipment package (EQ392) from the Category III CPT code 0448T.

CT Modifier Reduction List

We are adding HCPCS code 71271 (Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)) to the list of codes contained within CR 9250. CR 9250 lists what CPT codes are subject to a 15% reduction in payment for the technical component for CT services.

For the full list of codes included on the CT modifier reduction list, please see the related article MM9250, which you'll find at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9250.pdf.

CPT Codes that CMS Finalized as Contractor Priced: Remote Retinal Imaging (CPT code 92229)

We are finalizing CPT code 92229 (Imaging of retina for detection or monitoring of disease; with point-of-care automated analysis with diagnostic report; unilateral or bilateral) for point-of-care automated analysis that uses innovative Artificial Intelligence (AI) technology to perform the interpretation of the eye exam, without requiring that an ophthalmologist interpret the results as a diagnostic service. This code will be contractor priced. As part of this service, the AMA RVS Update Committee recommended a $25 "per click" analysis fee for remote imaging that is conducted by AI software. As our PE data have aged and AI applications are emerging, we recognize that issues involving the use of AI are complex. While we agree that the costs for AI applications should be accounted for in payment, AI applications aren't well accounted for in our PE methodology.

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There are previous approaches that have been used for establishing payments for other services that use algorithms or AI components to render key portions of a service. For example, in the CMS CY 2018 OPPS final rule (82 FR 59284), we discussed the Fractional Flow Reserve Computed Tomography (FFRCT) service. We noted that the service, which we considered to be separate and distinct from the original coronary computed tomography angiography service isn't an image processing service, but rather the diagnostic output from the FFRCT reports functional flow values that can only be obtained using FFRCT. We found FFRCT to be similar to other technologies that use algorithms, AI, or other new forms of analysis to determine a course of treatment, where the analysis portion of the service can't adequately be reflected under the MPFS payment methodology. Accordingly, we established contractor pricing for the service and have continued to gather information from stakeholders on payment that appropriately reflects resource cost for this service under the MPFS payment methodology. Our recent reviews of the overall cost for the service and specifically for the analysis component of the service have shown the costs to be similar to the costs reflected in payment under the CY 2021 OPPS final rule for CPT code 0503T (analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model).

Additional Information

The official instruction, CR 12071, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10505cp.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
December 4, 2020	Initial article released.

International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--April 2021

MLN Matters Number: MM12027 Revised
Related CR Release Date: December 10, 2020
Related CR Transmittal Number: R10515NCD
Related Change Request (CR) Number: 12027
Effective Date: April 1, 2021
Implementation Date: December 16, 2020, MACs, April 5, 2021. Shared System Maintainers

Note: We revised this article due to a revised CR12027 that CMS issued on December 10. The CR revision didn't impact the substance of this 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 physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article informs you about updated ICD-10 conversions as well as coding updates specific to National Coverage Determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Any policy-related changes to NCDs continue to be implemented via the current, longstanding NCD process. There are no policy-related changes with these updates. Make sure your billing staffs are aware of these updates.

Background
Previous NCD coding changes appear in ICD-10 quarterly updates that are available at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html along with other CRs implementing new NCD policy. Edits to ICD-10, and other coding updates specific to NCDs, will be included in subsequent quarterly releases as needed.

Note: Coding (as well as payment) is a separate and distinct area of the Medicare Program from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by CMS and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Note: The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMs) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. As of October 1, 2019, the Centers for Medicare & Medicaid Services (CMS) no longer provides GEMs mappings.

Key Points in CR 12027
Relevant NCD coding changes in CR 12027 include:
- NCD 20.5 Extracorporeal Immunoadsorption Using Protein A Columns
- NCD 20.33 Transcatheter Mitral Valve Regurgitation (TMVR)

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- NCD 110.10 IV Iron Therapy
- NCD 110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions
- NCD 110.23 Stem Cell Transplants
- NCD 160.18 Vagus Nerve Stimulation (VNS)
- NCD 180.1 Medical Nutrition Therapy
- NCD 190.3 Cytogenetic Studies
- NCD 210.6 Hepatitis B Virus (HBV) Screening
- NCD220.4 Mammograms
- NCD220.6.17 PET for Solid Tumors
- NCD 220.13 Percutaneous Image-Guided Breast Biopsy
- NCD 260.1 Adult Liver Transplants

Please follow the link below for the NCD spreadsheets included with this CR:
https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR12027.zip

For those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

The MACs use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages, where appropriate. When denying claims associated with the attached NCDs, except where otherwise indicated, the MACs will use these messages:

- Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119. See latest CAQH CORE update.
- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is on file).
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
- For modifier GZ, CARC 50 is used.

Note: MACs will adjust any claims processed in error associated with CR 12027 that you bring to their attention.

Additional Information
The official instruction, CR 12027, issued to your MAC regarding this change, is available at https://www.cms.gov/files/document/r10515otn.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
December 10, 2020	We revised this article due to a revised CR12027 that CMS issued on December 10. The CR revision didn't impact the substance of this article. We revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.
November 4, 2020	Initial article released.

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2020

MLN Matters Number: MM11889 Revised
Related CR Release Date: August 14, 2020
Related CR Transmittal Number: R10305NCD
Related Change Request (CR) Number: 11889
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

Note: We revised this article to reflect the revised CR 11889 issued on August 14. The CR revision updated the codes in the CR spreadsheet for NCD 190.15. That change did not impact the article. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

Provider Types Affected
This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article announces the changes that will be included in the October 2020 quarterly release of the edit module for clinical diagnostic laboratory services. Please be sure your billing staffs are aware of these updates.

Background
The laboratory negotiated rulemaking committee developed the National Coverage Determinations (NCDs) for clinical diagnostic laboratory services, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems, so that laboratory claims subject to one of the 23 NCDs (see Medicare National Coverage Determination, Sections 190.12 - 190.34) were processed uniformly throughout the nation, effective April 1, 2003.

In accordance with the Medicare Claims Processing Manual, Chapter 16, Section 120.2, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.

CR 11889 communicates requirements to Medicare's Shared System Maintainers (SSMs) and MACs, notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for October 2020.

You may access the NCD spreadsheet included with CR 11889 at https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/October2020.zip.

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Note: MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims unless you bring such claims to their attention.

Additional Information

The official instruction, CR 11889, issued to your MAC regarding this change, is available at https://www.cms.gov/files/document/r10305cp.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
November 30, 2020	Note: We revised this article to reflect the revised CR 11889 issued on August 14. The CR revision updated the codes in the CR spreadsheet for NCD 190.15. That change did not impact the article. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.
July 10, 2020	Initial article released.

2021 Annual Update of Per-Beneficiary Threshold Amounts

MLN Matters Number: MM12014
Related CR Release Date: November 13, 2020
Related CR Transmittal Number: R10464CP
Related Change Request (CR) Number: 12014
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

Provider Types Affected
This MLN Matters Article is for physicians, therapists, and other providers submitting claims to MACs, including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider Action Needed
Related CR 12014 updates the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for Calendar Year (CY) 2021. These amounts were previously associated with the financial limitation amounts that Medicare more commonly referred to as "therapy caps." The Bipartisan Budget Act (BBA) of 2018 repealed those caps while also retaining and adding limitations to ensure appropriate therapy.

For CY 2021, the KX modifier threshold amounts are:
$2,110 for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined, and
$2,110 for Occupational Therapy (OT) services.

Please make sure your billing staffs are aware of these updates.

Background
A provision of Section 50202 of the BBA of 2018 adds Section 1833(g)(7)(A) of the Social Security Act (the Act) to preserve the former therapy cap amounts as thresholds above which claims must include the KX modifier to confirm that services are medically necessary as justified by appropriate documentation in the medical record. These amounts are now known as the KX modifier thresholds. There is one amount for PT and SLP services combined and a separate amount for OT services. Medicare will deny claims from suppliers or providers for therapy services above these amounts without the KX modifier.

These per-beneficiary amounts under Section 1833(g) of the Act (as amended by the 1997 BBA) are updated each year by the Medicare Economic Index (MEI).

Section 50202 of the BBA of 2018 also adds Section 1833(g)(7)(B) of the Act to maintain the targeted medical review process (first established through Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015) but at a lower threshold amount of $3,000. Medicare now refers to this threshold amount as the Medical Record (MR) threshold amount – one MR threshold amount for PT and SLP services combined and another for OT services. This amount remains at $3,000 until CY 2028 at which time Medicare will update it based on the MEI.

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Additional Information

The official instruction, CR 12014, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10464CP.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
December 7, 2020	Initial article released.

MLN Connects™

MLN Connects contains a week's worth of Medicare-related messages instead of many different messages being sent to you throughout the week. This notification process ensures planned, coordinated messages are delivered timely about Medicare-related topics.

MLN Connects™ for November 25, 2020
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-11-25-mlnc

MLN Connects™ for December 3, 2020
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-12-03-mlnc

MLN Connects™ for December 10, 2020
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-12-10-mlnc

MLN Connects™ for December 17, 2020
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-12-17-mlnc

Special Edition – Tuesday, December 1, 2020, Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients
On December 1, CMS released the annual Physician Fee Schedule (PFS) final rule, prioritizing CMS' investment in primary care and chronic disease management by increasing payments to physicians and other practitioners for the additional time they spend with patients, especially those with chronic conditions. The rule allows non-physician practitioners to provide the care they were trained and licensed to give, cutting red tape so health care professionals can practice at the top of their license and spend more time with patients instead of on unnecessary paperwork. This final rule takes steps to further implement President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors including prioritizing the expansion of proven alternatives like telehealth.

"During the COVID-19 pandemic, actions by the Trump Administration have unleashed an explosion in telehealth innovation, and we're now moving to make many of these changes permanent," said HHS Secretary Alex Azar. "Medicare beneficiaries will now be able to receive dozens of new services via telehealth, and we'll keep exploring ways to deliver Americans access to health care in the setting that they and their doctor decide makes sense for them."

"Telehealth has long been a priority for the Trump Administration, which is why we started paying for short virtual visits in rural areas long before the pandemic struck," said CMS Administrator Seema Verma. "But the pandemic accentuated just how transformative it could be, and several months in, it's clear that the health care system has adapted seamlessly to a historic telehealth expansion that inaugurates a new era in health care delivery."

Finalizing Telehealth Expansion and Improving Rural Health

Before the COVID-19 Public Health Emergency (PHE), only 15,000 Fee-for-Service beneficiaries each week received a Medicare telemedicine service. Since the beginning of the PHE, CMS has added 144 telehealth services, such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services, that are covered by Medicare through the end of the PHE. These services were added to allow for safe

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access to important health care services during the PHE. As a result, preliminary data show that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees have received a Medicare telemedicine service during the PHE.

This final rule delivers on the President's recent Executive Order on Improving Rural Health and Telehealth Access by adding more than 60 services to the Medicare telehealth list that will continue to be covered beyond the end of the PHE, and we will continue to gather more data and evaluate whether more services should be added in the future. These additions allow beneficiaries in rural areas who are in a medical facility (like a nursing home) to continue to have access to telehealth services such as certain types of emergency department visits, therapy services, and critical care services. Medicare does not have the statutory authority to pay for telehealth to beneficiaries outside of rural areas or, with certain exceptions, allow beneficiaries to receive telehealth in their home. However, this is an important step, and as a result, Medicare beneficiaries in rural areas will have more convenient access to health care.

Additionally, CMS is announcing a commissioned study of its telehealth flexibilities provided during the COVID-19 PHE. The study will explore new opportunities for services where telehealth and virtual care supervision, and remote monitoring can be used to more efficiently bring care to patients and to enhance program integrity, whether they are being treated in the hospital or at home.

Payment for Office/Outpatient Evaluation and Management (E/M) and Comparable Visits

Last year, CMS finalized a historic increase in payment rates for office/outpatient face-to-face E/M visits that goes into effect in 2021. The Medicare population is increasing, with over 10,000 beneficiaries joining the program every day. Along with this growth in enrollment is increasing complexity of beneficiary health care needs, with more than two-thirds of Medicare beneficiaries having two or more chronic conditions. Increasing the payment rate of E/M office visits recognizes this demand and ensures clinicians are paid appropriately for the time they spend on coordinating care for patients, especially those with chronic conditions. These payment increases, informed by recommendations from the American Medical Association (AMA), support clinicians who provide crucial care for patients with dementia or manage transitions between the hospital, nursing facilities, and home.

Under this final rule, CMS continues to prioritize this investment in primary care and chronic disease management by similarly increasing the value of many services that are similar to E/M office visits, such as maternity care bundles, emergency department visits, end-stage renal disease capitated payment bundles, and physical and occupational therapy evaluation services. These adjustments ensure CMS is appropriately recognizing the kind of care where clinicians need to spend more face-to-face time with patients.

"This finalized policy marks the most significant updates to E/M codes in 30 years, reducing burden on doctors imposed by the coding system and rewarding time spent evaluating and managing their patients' care," Administrator Verma added. "In the past, the system has rewarded interventions and procedures over time spent with patients – time taken preventing disease and managing chronic illnesses."

In addition to the increase in payment for E/M office visits, simplified coding and documentation changes for Medicare billing for these visits will go into effect beginning January 1, 2021. The changes modernize documentation and coding guidelines developed in the 1990s, and come after extensive stakeholder collaboration

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with the AMA and others. These changes will significantly reduce the burden of documentation for all clinicians, giving them greater discretion to choose the visit level based on either guidelines for medical decision-making (the process by which a clinician formulates a course of treatment based on a patient's information, i.e., through performing a physical exam, reviewing history, conducting tests, etc.) or time dedicated with patients. These changes are expected to save clinicians 2.3 million hours per year in administrative burden so that clinicians can spend more time with their patients.

Professional Scope of Practice and Supervision

As part of the Patients Over Paperwork Initiative, the Trump Administration is cutting red tape so that health care professionals can practice at the top of their license and spend more time with patients instead of on unnecessary paperwork. The PFS final rule makes permanent several workforce flexibilities provided during the COVID-19 PHE that allow non-physician practitioners to provide the care they were trained and licensed to give, without imposing additional restrictions by the Medicare program.

Specifically, CMS is finalizing the following changes:

Certain non-physician practitioners, such as nurse practitioners and physician assistants, can supervise the performance of diagnostic tests within their scope of practice and state law, as they maintain required statutory relationships with supervising or collaborating physicians.

Physical and occupational therapists will be able to delegate "maintenance therapy" – the ongoing care after a therapy program is established – to a therapy assistant.

Physical and occupational therapists, speech-language pathologists, and other clinicians who directly bill Medicare can review and verify, rather than re-document, information already entered by other members of the clinical team into a patient's medical record. As a result, practitioners have the flexibility to delegate certain types of care, reduce duplicative documentation, and supervise certain services they could not before, increasing access to care for Medicare beneficiaries.

For More Information:
Final Rule (PDF): https://www.cms.gov/files/document/12120-pfs-final-rule.pdf

Physician Fee Schedule Final Rule fact sheet:
https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1

Quality Payment Program Final Rule fact sheet and FAQs:
https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1207/2021%20QPP%20Final%20Rule%20Resources.zip

Medicare Diabetes Prevention Program fact sheet:
https://www.cms.gov/newsroom/fact-sheets/final-policies-medicare-diabetes-prevention-program-mdpp-expanded-model-calendar-year-2021-medicare

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Special Edition – Wednesday, December 2, 2020: Trump Administration Finalizes Policies to Give Medicare Beneficiaries More Choices around Surgery

Outpatient Prospective Payment System and Ambulatory Surgical Center final rule empowers beneficiary choices and unleashes competition to lower costs and improve innovation

On December 2, CMS finalized policy changes that will give Medicare patients and their doctors greater choices to get care at a lower cost in an outpatient setting. The Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) final rules will increase value for Medicare beneficiaries and reflect the agency's efforts to transform the health care delivery system through competition and innovation. These changes implement the Trump Administration's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors, and will take effect on January 1, 2021.

"President Trump's term in office has been marked by an unrelenting drive to level the playing field and boost competition at every turn," said CMS Administrator Seema Verma. "Today's rule is no different. It allows doctors and patients to make decisions about the most appropriate site of care, based on what makes the most sense for the course of treatment and the patient without micromanagement from Washington."

In this final rule, CMS will begin eliminating the Inpatient Only (IPO) list of 1,700 procedures for which Medicare will only pay when performed in the hospital inpatient setting over a three-year transitional period, beginning with some 300 primarily musculoskeletal-related services. The IPO list will be completely phased out by CY 2024. This will make these procedures eligible to be paid by Medicare when furnished in the hospital outpatient setting when outpatient care is appropriate, as well as continuing to be payable when furnished in the hospital inpatient setting when inpatient care is appropriate, as determined by the physician. In the short term, as hospitals face surges in patients with complications from COVID-19, being able to provide treatment in outpatient settings will allow non-COVID-19 patients to get the care they need.

In addition to putting decisions on the best site of care in the hands of physicians, allowing more procedures to be done in an outpatient setting also provides for lower-cost options that benefit the patient.

For example, thromboendarterectomy (HCPCS code 35372) is a surgical procedure that removes chronic blood clots from the arteries in the lung. If this procedure is performed in an inpatient setting, a patient who has not had other health care expenses that year would have a deductible of about $1500. In contrast, the copayment for this procedure for the same patient in the outpatient setting would be about $1150. Patient safety and quality of care will be safeguarded by the doctor's assessment of the risk of a procedure or service to the individual beneficiary and their selection of the most appropriate setting of care based on this risk. This is in addition to state and local licensure requirements, accreditation requirements, hospital conditions of participation, medical malpractice laws, and CMS quality and monitoring initiatives and programs.

Beginning January 1, 2021, we are adding eleven procedures to the ASC Covered Procedures List (CPL), including total hip arthroplasty (CPT 27130), under our standard review process. Additionally, we are revising the criteria we use to add surgical procedures to the ASC CPL, providing that certain criteria we used to add surgical procedures to the ASC CPL in the past will now be factors for physicians to consider in deciding whether a specific beneficiary should receive a covered surgical procedure in an ASC. Using our revised criteria, we are adding an additional 267 surgical procedures to the ASC CPL beginning January 1, 2021. Finally, we are adopting a notification process for surgical procedures the public believes can be added to the ASC CPL under the criteria we are retaining.

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CMS is announcing that it will continue its policy of paying for 340B-acquired drugs at average sales price minus 22.5% after the July 31, 2020, decision of the Court of Appeals for the D.C. Circuit upholding the current policy. This policy lowers out-of-pocket drug costs for Medicare beneficiaries by letting them share in the discount that hospitals receive under the 340B program. Since this policy went into effect in 2018, Medicare beneficiaries have saved nearly $1 billion on drug costs, with expected Medicare beneficiary drug cost savings of over $300 million in CY 2021.

As part of the agency's Patients Over Paperwork Initiative, which is aimed at reducing burden for health care providers, CMS is establishing a simple updated methodology to calculate the Overall Hospital Quality Star Rating (Overall Star Rating). The Overall Star Rating summarizes a variety of quality measures published on the Medicare.gov Care Compare tool (the successor to Hospital Compare) for common conditions that hospitals treat, such as heart attacks or pneumonia. Along with publicly reported data on Care Compare, the Overall Star Rating helps patients make better-informed health care decisions. Veterans Health Administration hospitals will be added to CMS' Care Compare, which will help veterans understand hospital quality within the VA system. Overall, these changes will reduce provider burden, improve the predictability of the star ratings, and make it easier for patients to compare ratings between similar hospitals.

In response to stakeholder feedback about the current methodology used to calculate the Overall Star Rating, CMS is not finalizing its proposal to stratify readmission measures under the new methodology based on dually eligible patients, but will continue to study the issue to find the best way to convey quality of care for this vulnerable population.

Finally, in order to address the ongoing public health emergency, CMS is finalizing a new requirement for the nation's 6,200 hospitals and critical access hospitals to report information about their inventory of therapeutics to treat COVID-19. This reporting will provide the information needed to track and accurately allocate therapeutics to the hospitals that need additional inventory to care for patients and meet surge needs.

For More Information:
Final Rule (PDF):
https://www.cms.gov/files/document/12220-opps-final-rule-cms-1736-fc.pdf

Fact Sheet:
https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

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Special Edition – Thursday, December 3, 2020: COVID-19 Antibody Treatment and Enforcement Discretion Reminder

CMS Takes Further Steps to Ensure Medicare Beneficiaries Have Wide Access to COVID-19 Antibody Treatment

The U.S. Food and Drug Administration issued an Emergency Use Authorization (EUA) for the investigational monoclonal antibody therapy, casirivimab and imdevimab, administered together, for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients with positive COVID-19 test results who are at high risk for progressing to severe COVID-19 and/or hospitalization. Casirivimab and imdevimab, administered together, may only be administered in settings in which health care providers have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis, and the ability to activate the Emergency Medical System (EMS), as necessary. Review the Fact Sheet (https://www.fda.gov/media/143892/download) for Health Care Providers EUA of Casirivimab and Imdevimab regarding the limitations of authorized use when administered together.

During the COVID-19 Public Health Emergency (PHE), Medicare will cover and pay for these infusions the same way it covers and pays for COVID-19 vaccines (when furnished consistent with the EUA).

CMS identified specific code(s) for the monoclonal antibody product and specific administration code(s) for Medicare payment: Regeneron's Antibody Casirivimab and Imdevimab (REGN-COV2) (ZIP), EUA effective November 21, 2020. https://www.fda.gov/media/143891/download

Q0243:
Long descriptor: Injection, casirivimab and imdevimab, 2400 mg
Short descriptor: casirivimab and imdevimab

M0243:
Long Descriptor: intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring
Short Descriptor: casirivi and imdevi infusion

Additional Resources:
List COVID-19 monoclonal antibody infusion billing codes, payment allowances and effective dates:
https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies

Monoclonal Antibody COVID-19 Infusion Program Instruction (PDF):
https://www.cms.gov/files/document/covid-medicare-monoclonal-antibody-infusion-program-instruction.pdf

CMS COVID-19 Vaccine Provider Toolkit:
https://www.cms.gov/covidvax-provider

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COVID-19 Vaccines and Monoclonal Antibody Infusion: Enforcement Discretion Relating to SNF Consolidated Billing

To facilitate the efficient administration of COVID-19 vaccines to Skilled Nursing Facility (SNF) residents, CMS is exercising enforcement discretion with respect to statutory provisions requiring consolidated billing by SNFs as well as any associated statutory references and implementing regulations, including as interpreted in pertinent guidance. Through the exercise of this discretion, we will allow Medicare-enrolled immunizers working within their scope of practice and subject to applicable state law, including, but not limited to, pharmacies working with the United States, as well as infusion centers, and home health agencies, to bill directly and receive direct reimbursement from the Medicare program for vaccinating Medicare Part A SNF residents. This enforcement discretion, and accordingly the ability for entities other than the SNF to submit claims for these monoclonal antibody products and their administration furnished to Medicare Part A SNF residents, is limited to the period described in the above-cited enforcement discretion notice.

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Special Edition – Wednesday, December 9, 2020: COVID-19: Medicare Coverage of Antibody Treatment
In Case You Missed It: CMS Announces Guidance for Medicare Coverage of COVID-19 Antibody Treatment

On December 9, CMS posted updates to FAQs and an infographic about coverage and payment for monoclonal antibodies to treat COVID-19. The FAQs include general payment and billing guidance for these products, including questions on different setting types. The infographic has key facts about expected Medicare payment to providers and information about how Medicare beneficiaries can receive these innovative COVID-19 treatments with no cost-sharing during the public health emergency (PHE). CMS' November 10, 2020 announcement (https://www.cms.gov/newsroom/press-releases/cms-takes-steps-ensure-medicare-beneficiaries-have-wide-access-covid-19-antibody-treatment) about coverage of monoclonal antibody therapies allows a broad range of providers and suppliers, including freestanding and hospital-based infusion centers, home health agencies, nursing homes, and entities with whom nursing homes contract, to administer this treatment in accordance with the Food & Drug Administration's Emergency Use Authorization (EUA), and bill Medicare to administer these infusions. Currently, two monoclonal antibody therapies have received EUA's for treatment of COVID-19.

For more information:
Therapeutics Coverage Infographic (PDF):
https://www.cms.gov/files/document/covid-infographic-coverage-monoclonal-antibody-products-treat-covid-19.pdf

Section BB of the FAQs (PDF): billing and payment for COVID-19 monoclonal antibody treatments,
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Monoclonal toolkit and program guidance:
https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion

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Special Edition – Thursday, December 10, 2020: CMS Proposes New Rules to Address Prior Authorization and Reduce Burden on Patients and Providers

On December 10, under President Trump's leadership, CMS issued a proposed rule that would improve the electronic exchange of health care data among payers, providers, and patients and streamline processes related to prior authorization to reduce burden on providers and patients. By both increasing data flow and reducing burden, this proposed rule would give providers more time to focus on their patients and provide better quality care.

For More Information:
Proposed Rule (PDF): Comment period closes January 4:
https://www.cms.gov/files/document/121020-reducing-provider-and-patient-burden-cms-9123-p.pdf

Full press release:
https://www.cms.gov/newsroom/press-releases/cms-proposes-new-rules-address-prior-authorization-and-reduce-burden-patients-and-providers

Fact sheet:
https://www.cms.gov/newsroom/fact-sheets/reducing-provider-and-patient-burden-improving-prior-authorization-processes-and-promoting-patients

Blog:
https://www.cms.gov/blog/reducing-provider-and-patient-burden-and-promoting-patients-electronic-access-health-information

CMS Interoperability and Patient Access Final Rule webpage:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index

Register for December 16 listening session
https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index

CMS Proposes New Rules to Address Prior Authorization and Reduce Burden on Patients and Providers

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Special Edition – Monday, December 14, 2020: COVID-19 Vaccine Codes: Updated Effective Date for Pfizer-BioNTech

On December 11, 2020, the U.S. Food and Drug Administration issued an Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID 19 Vaccine(https://www.fda.gov/media/144412/download) for the prevention of COVID-19 for individuals 16 years of age and older. Review Pfizer's Fact Sheet (https://www.fda.gov/media/144413/download) for Healthcare Providers Administering Vaccine (Vaccination Providers) regarding the limitations of authorized use.

During the COVID-19 Public Health Emergency (PHE), Medicare will cover and pay for the administration of the vaccine (when furnished consistent with the EUA). Review our updated payment and HCPCS Level I CPT code structure (https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies) for specific COVID-19 vaccine information. Only bill for the vaccine administration codes when you submit claims to Medicare; don't include the vaccine product codes when vaccines are free.

Related links:
CMS COVID-19 Provider Toolkit:
https://www.cms.gov/covidvax-provider

CMS COVID-19 FAQs:
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

CDC COVID-19 Vaccination Communication Toolkit for medical centers, clinics, and clinicians:
https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html

FDA COVID-19 Vaccines webpage:
https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines

CMS Offers FREE Medicare Training for Providers

CMS Web Training

The Centers for Medicare & Medicaid Services (CMS) has launched a series of education and training programs designed to leverage emerging Internet and satellite technologies to offer just-in-time training to Medicare providers and suppliers throughout the United States. Many of these programs include free, downloadable computer/Web based training courses. These courses are also available on CD-ROM.

https://www.cms.gov/MLNGenInfo

Railroad Medicare Customer Information and Outreach

Important Telephone Numbers

Provider Contact Center
888-355-9165

Interactive Voice Response (IVR) System
877-288-7600

Telephone Reopenings
888-355-9165

Electronic Data Interchange (EDI)
Technical Support
888-355-9165

Beneficiary Contact Center
800-833-4455
TTY 877-566-3572

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Attention: Billing Manager