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For Home Health Providers

MM11272 (Revised): Home Health (HH) Patient-Driven Groupings Model (PDGM) – Additional Manual Instructions

The Centers for Medicare & Medicaid Services (CMS) revised the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles

MLN Matters Number: MM11272 Revised
Related CR Release Date: May 23, 2019
Related CR Transmittal Number: R4312CP
Implementation Date: August 7, 2019

Related Change Request (CR) Number: 11272
Effective Date: Claim “From” dates on or after January 1, 2020

Note: We revised this article on May 24, 2019, to reflect the revised CR 11272 issued on May 23. CMS revised the CR to show that the new diagnosis instructions added to section 40.2 (HH claims) also apply to section 40.1 (RAPs) and we revised the article accordingly. Also, we revised the CR release date, transmittal number, and the Web address of the CR. All other information remains the same.

Provider Type Affected
This MLN Matters Article is for physicians and Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for Home Health services provided to Medicare beneficiaries.

Provider Action Needed
CR 11272 revises additional sections in Chapter 10 of the Medicare Claims Processing Manual to support the implementation of the Home Health (HH) Patient-Driven Groupings Model (PDGM). Make sure your billing staffs are aware of these revisions.

Background
The Centers for Medicare & Medicaid Services (CMS) finalized an alternative case-mix method now called the Patient-Driven Groupings Model (PDGM), which includes the payment reform requirements set forth in the Bipartisan Budget Act of 2018 (BBA). CMS discussed this model in the Calendar Year (CY) 2019 final Home Health (HH) Prospective Payment System Rate Update final rule. CMS will implement this in CY 2020, effective for claims with From dates on or after January 1, 2020.

CR 11272 revises manual instructions to conform to the final policies of the PDGM. It also further implements the policies of the PDGM, as the CY 2019 HH final rule describes

The revised Manual sections are part of CR11272. One manual change is that episode is also now a period of care. HHAs should note the following instructions in the revised Medicare Claims Processing Manual, Chapter 10, Section 40.2:

- HH PPS claims must report a 0023 revenue code line on which the first four positions of the HIPPS code match the code submitted on the RAP. This HIPPS code is used to match the claim to the corresponding RAP that was previously paid. After this match is completed, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems. At that time, the submitted HIPPS code on the claim will be replaced with the system-calculated code.

- Principal Diagnosis Code
  - For claim “From” dates before January 1, 2020, the ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).
  - For claim “From” dates on or after January 1, 2020, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.
  - Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment – RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no requirement for the HHA to complete another follow-up (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment.

- Other Diagnosis Codes
  - For claim “From” dates before January 1, 2020, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses).
  - For claim “From” dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.

  Note: The above instructions from Chapter 10, Section 40.2 pertaining to principal diagnosis code and other diagnosis codes also apply to RAPs, as the revised Chapter 10, Section 40.1 indicates.

HHAs may also want to review the revised Sections 70.3 (Decision Logic Used by the Pricer on RAPs) and 70.4 (Decision Logic Used by the Pricer on Claims). These revised sections are part of the manual revision that is attached to CR 11272.

Also, CMS added guidance for HHAs in case the MAC returns a claim because there is no corresponding OASIS assessment in Medicare’s systems related to the claim. In such cases, the HHA may correct any errors in the OASIS or claim information to ensure a match and then re-submit the claim. If there was no error and the HHA determines the claim did not meet the condition of payment, the HHA may bill for denial using the following coding:

- Type of Bill (TOB) 0320 indicating the expectation of a full denial for the billing period
- Occurrence span code 77 with span dates matching the From/Through dates of the claim, indicating the HHA’s acknowledgment of liability for the billing period
- Condition code D2, indicating that the HHA is changing the billing for the Health Insurance Prospective Payment System (HIPPS) code to non-covered.
Do not use condition code 21 in these instances, since it would result in inappropriate beneficiary liability.

The MACs will use the following remittance advice messages and associated codes when processing billings for denial under this policy. This Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) combination is compliant with Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Business Scenario Three.

- Group Code: CO
- CARC: 272
- RARC: N211

**Additional Information**


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

**Document History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 24, 2019</td>
<td>We revised the article to reflect the revised CR 11272 issued on May 23. CMS revised the CR to show that the new diagnosis instructions added to section 40.2 (HH claims) also apply to section 40.1 (RAPs) and we revised the article accordingly. Also, we revised the CR release date, transmittal number, and the Web address of the CR. All other information remains the same.</td>
</tr>
<tr>
<td>May 3, 2019</td>
<td>Initial article released.</td>
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**For Home Health Providers**

**SE17027 (Revised):** Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device

The Centers for Medicare & Medicaid Services (CMS) revised the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles)

**MLN Matters Number:** SE17027 _Revised_  
**Article Release Date:** June 11, 2019  
**Related Change Request (CR) Number:** N/A  
**Effective Date:** N/A  
**Related CR Transmittal Number:** N/A  
**Implementation Date:** N/A

**Note:** We revised this article on June 11, 2019, to clarify the description for coding the TOT UNIT/COV UNIT field on Type of Bill 34X on page 6. The change shows that HHAs should report 1 in this field. All other information remains the same.

**Provider Types Affected**

This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Home Health & Hospice Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
What You Need to Know
This Special edition MLN Matters article is informational only and is intended to provide helpful information to providers. The article does not reflect any change in Medicare policy.

Background
The Consolidated Appropriations Act, 2016 (Pub. L 114-113) requires a separate payment to be made to Home Health Agencies (HHAs) for disposable Negative Pressure Wound Therapy (NPWT) devices when furnished, on or after January 1, 2017, to an individual who receives home health services for which payment is made under the Medicare home health benefit. In the CY 2017 HH PPS Final Rule, the Centers for Medicare & Medicaid Services (CMS) finalized policies related to payment for furnishing NPWT using a disposable device under a home health plan of care.

Reporting NPWT Services using a Disposable Device
Effective January 1, 2017, Medicare makes a separate payment amount for a disposable Negative Pressure Wound Therapy (NPWT) device for a patient under a home health plan of care. Payment is equal to the amount of the payment that would otherwise be made under the Outpatient Prospective Payment System (OPPS).

Disposable NPWT services are billed using the following Current Procedural Terminology® (CPT®) codes:

- 97607 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.
- 97608 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.

The HHA reports the CPT® code with one of three revenue codes, depending on the practitioner that provided the service:

- Skilled nurse – 0559
- Physical therapist – 042x
- Occupational therapy – 043x.

When using revenue codes 042x or 043x, the HHA should not use the therapy plan of care modifiers (GO or GP) for NPWT services.

There are no additional documentation requirements for the provision of NPWT using a disposable device. The HHA documentation (and any supporting documentation leading to the order for home health and NPWT using a disposable device) should support that the patient needs wound care using NPWT. The medical necessity and documentation requirements would be no different than what is currently required when patients receive wound care from a home health nurse when the patient is receiving conventional NPWT. HHAs may also follow their own internal policies and procedures for documenting clinical information in the patient’s medical record beyond those required by regulation.

Billing for dNPWT Services
The (CPT®) codes for furnishing NPWT using a disposable device include both performing the service and the disposable NPWT device, which is defined as an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy. Services related to the furnishing NPWT
using a disposable device that do not encompass the placement or replacement of the entire integrated system should be billed per existing HH PPS guidelines.

- When furnishing NPWT using a disposable device, both the device and the services associated with furnishing the device are paid for separately based on the OPPS amount.

- When a HHA furnishes NPWT using a disposable device, the HHA is furnishing a new disposable NPWT device.
  - This means the HHA provider is either initially applying an entirely new disposable NPWT device, or removing a disposable NPWT device and replacing it with an entirely new one.
  - In both cases, all the services associated with NPWT—for example, conducting a wound assessment, changing dressings, and providing instructions for ongoing care—must be reported on TOB 34x with the corresponding CPT® code (that is, CPT® code 97607 or 97608); they may not be reported on the home health claim (TOB 32x).
  - The reimbursement for all of these services is included in the OPPS reimbursement amount for those two CPT® codes.
  - Any follow-up visits for wound assessment, wound management, and dressing changes where a new disposable NPWT device is not applied must be included on the home health claim (TOB 32x).

Some example billing scenarios for HHAs furnishing NPWT using a disposable device are provided below:

<table>
<thead>
<tr>
<th>Clinical Scenario</th>
<th>Appropriate Billing Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scenario 1:</strong> A nurse assesses the patient’s condition, assesses the wound, and applies a new disposable NPWT device. The nurse also provides wound care education to the patient and family. On the following Monday, the nurse returns, assesses the wound, and replaces the device that was applied the week before with an entirely new disposable NPWT device.</td>
<td>All services provided by the nurse were associated with furnishing NPWT using a disposable device because the nurse applied a new disposable NPWT device during each visit. The nurse did not provide any services other than furnishing NPWT using a disposable device. Therefore, all the nursing services for both visits should be reported on TOB 34x with CPT® code 97607 or 97608. None of the services should be reported on TOB 32x.</td>
</tr>
<tr>
<td><strong>Scenario 2:</strong> On Monday, a nurse assesses a wound, applies a new disposable NPWT device, and provides wound care education to the patient and family. The nurse returns on Thursday for wound assessment and replaces the fluid management system (or dressing) for the existing disposable NPWT, but does not replace the entire device. The nurse returns the following Monday, assesses the patient’s condition and the wound, and replaces the device that had been applied on the previous Monday with a new disposable NPWT device.</td>
<td>For both Monday visits, all the services provided by the nurse were associated with furnishing NPWT using a disposable device. The nurse did not provide any services that were not associated with furnishing NPWT using a disposable device. Therefore, all the nursing services for both Monday visits should be reported on TOB 34x with CPT® code 97607 or 97608. None of the services should be reported on TOB 32x. For the Thursday visit, the nurse checked the wound, but did not apply a new disposable NPWT device, so even though the nurse provided care related to the wound, those services would not be considered furnishing NPWT using a disposable device. Therefore, the services should be reported on bill type 32x and no services should be reported on bill type 34x.</td>
</tr>
<tr>
<td><strong>Scenario 3:</strong> On Monday, the nurse applies a new disposable NPWT device. On Thursday, the nurse returns for a scheduled visit to change the beneficiary’s indwelling catheter. While there, the nurse assesses the wound and applies a new fluid management system (or dressing) for the existing disposable NPWT device, but does not replace the device entirely.</td>
<td>For the Monday visit, all the nursing services were associated with furnishing NPWT using a disposable device. The nurse did not provide any services that were not associated with furnishing NPWT using a disposable device. Therefore, the HHA should report the nursing visit on TOB 34x with CPT® code 97607 or 97608; the visit should not be reported on a 32x claim. For the Thursday visit, while the nursing services included wound assessment and application of a component of the disposable NPWT device, the nurse did not furnish a new disposable NPWT device. Therefore, the nurse did not furnish NPWT using a disposable device, so the HHA should report all the nursing services for the visit, including the catheter change and the wound care, on TOB 32x.</td>
</tr>
</tbody>
</table>
### Scenario 4:
On Monday, the nurse applies a new disposable NPWT device, and provides instructions for ongoing wound care. During this same visit, per the HH plan of care, the nurse changes the indwelling catheter and provides troubleshooting information and teaching regarding its maintenance.

The visit included applying a new disposable NPWT device as well as services unrelated to that NPWT service, which means the HHA will submit both a TOB 34x and a TOB 32x.

For furnishing NPWT using a disposable device, that is, the application of the new disposable NPWT device and the time spent instructing the beneficiary about ongoing wound care, the HHA would bill using a TOB 34x with CPT® code 97607 or 97608.

For services not associated with furnishing NPWT using a disposable device, that is, for the replacement of the indwelling catheter and instructions about troubleshooting and maintenance, the HHA would bill under TOB 32x.

In addition to the routine, required information for submission on Medicare claims, the following identifies specific information required for HHAs to submit NPWT using a disposable device on a 34X Type of Bill (TOB).

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOB</td>
<td>34X — Performing NPWT using a disposable device (integrated system of a vacuum pump, receptacle for collecting exudate, and dressings for the purpose of wound therapy)</td>
</tr>
<tr>
<td>STMT DATES FROM/TO</td>
<td>Enter the dates of service for the billing period. NOTE: the dates should fall within the &quot;FROM&quot; and &quot;TO&quot; dates for the HH PPS episode of care provided by the primary HHA.</td>
</tr>
<tr>
<td>REV</td>
<td>Report the appropriate revenue code. Valid codes are: 0559 – Skilled nurse (report HCPCS codes 97607 or 97608) 042X – Physical therapy 043X – Occupational therapy</td>
</tr>
<tr>
<td>HCPC</td>
<td>Enter the appropriate HCPCS code (report with revenue code 0559): 97607 — Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters. 97608 — Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.</td>
</tr>
<tr>
<td>TOT UNIT/COV UNIT</td>
<td>Report 1.</td>
</tr>
<tr>
<td>TOT CHARGES</td>
<td>Enter the total charge for all revenue codes.</td>
</tr>
<tr>
<td>SERV DATE</td>
<td>Enter the date the service was provided.</td>
</tr>
</tbody>
</table>


Medicare home health claims using either TOB 32x or 34x are submitted to MACs using the Fiscal Intermediary Standard System (FISS). Detailed instructions on using FISS are available on the MACs’ websites. You will find your MAC’s site at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

**Payment for NPWT Services using a Disposable Device**

Payment for CPT® codes 97607 and 97608 is set equal to the amount of the payment that would be made under the OPPS; therefore, the payment amount will also be subject to the area wage adjustment policies in place under the OPPS in a given year.

While there is typically no coinsurance, copayment, or deductible associated with home health services and supplies, coinsurance is required for both Durable Medical...
Equipment (DME) and furnishing NPWT using a disposable device covered as a home health service, which is defined as 20 percent of the payment amount. The amount paid to the HHA by Medicare would be equal to 80 percent of the lesser of the actual charge or the payment amount as determined by the OPPS for the year.

<table>
<thead>
<tr>
<th>Type of Bill</th>
<th>Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary Under Home Health Plan of Care and Services Fall Under Plan of</td>
<td>Deductible: No</td>
</tr>
<tr>
<td>Care (TOB 032X)</td>
<td>Coinsurance: No</td>
</tr>
<tr>
<td></td>
<td>Exception: Coinsurance applies on DME, NPWT using a disposable device, and orthotic/prosthetic claims.</td>
</tr>
<tr>
<td>Beneficiary Not Under Home Health Plan of Care, Services are Part B Medical</td>
<td>Deductible: Yes</td>
</tr>
<tr>
<td>and Other Health Services or Osteoporosis Injections (TOB 034x)</td>
<td>Coinsurance: Yes</td>
</tr>
<tr>
<td></td>
<td>Exception: Deductible and coinsurance may be waived for certain preventive services.</td>
</tr>
</tbody>
</table>

HHAs should conduct insurance benefit verification for CPT® codes 97607 and 97608 from both primary and secondary payers. It is required that providers bill for and make a good faith effort to collect the coinsurance from the patient’s secondary insurance. Consult the “Medicare Secondary Payer Manual” for detailed instructions: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html

HHAs are required to notify beneficiaries of any coinsurance responsibility if they do not have a secondary/supplemental insurance coverage. When coinsurance is applicable, and the patient does not have secondary insurance, the HHA should collect the appropriate amount from the patient.

As a reminder, home health billing transactions, including claims and adjustments, must be submitted no later than 12 months (or 1 calendar year) after the date the services were furnished.

Additional Information

HHA billing staff may want to review MLN Matters article MM9736 (based on CR9736), which is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9736.pdf. This article contains additional details regarding the provision of NPWT using a disposable device.

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

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

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</tr>
<tr>
<td>September 22, 2017</td>
<td>Initial article released</td>
</tr>
</tbody>
</table>
For Home Health and Hospice Providers

A SPEEDY Solution For Entering Letters Using Your Phone’s Keypad!

When using the Interactive Voice Response (IVR) and Computer Telephony Integration (CTI), do you find it time consuming when entering the letters of a Medicare Beneficiary Identifier (MBI)?

The MBI and Name to Number Converters at https://www.cgsmedicare.com/medicare_dynamic/j15/ivr_mbi_converters/ivr_mbi_converters.aspx will prove to become one of your BEST tools! Use it to convert the MBI and patient name into numbers....saving you TONS of time!

For Home Health and Hospice Providers

CGS Website Updates

CGS has recently made updates to their website, giving providers additional resources to assist with billing Medicare-covered services appropriately.

Please review the following updates:

- The Claims Processing Issues Log Web page at https://www.cgsmedicare.com/hhh/claims/j44_claims_processing_issues.html was updated with the most recent updates.

- The Top Claim Submission Errors (Reason Codes) and How to Resolve Web page at https://www.cgsmedicare.com/hhh/education/materials/cses.html has been updated with the most recent data.

- The HHH Recorded Webinars Web page at https://www.cgsmedicare.com/hhh/education/recorded_webinars.html was updated with the most recent home health and hospice related educational events.

- The Billing Negative Pressure Wound Therapy (NPWT) Web page at https://www.cgsmedicare.com/hhh/education/materials/3118.html was updated showing the new instruction for reporting the number “1” in the TOT UNIT/COV UNIT field on the type of bill 34X. Refer to the SE17027, Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17027.pdf

For Home Health and Hospice Providers

Fraud Alert: Genetic Testing Scam

The U.S. Department of Health and Human Services Office of Inspector General is alerting the public about a fraud scheme involving genetic testing.

Scammers are offering Medicare beneficiaries cheek swabs for genetic testing to obtain their Medicare information for identity theft or fraudulent billing purposes. Fraudsters are targeting beneficiaries through telemarketing calls, booths at public events, health fairs, and door-to-door visits.

If a beneficiary agrees to genetic testing or verifies personal or Medicare information, a testing kit is sent even if it is not ordered by a physician or medically necessary.
Protect Yourself

- If a genetic testing kit is mailed to you, don’t accept it unless it was ordered by your physician. Refuse the delivery or return it to the sender. Keep a record of the sender’s name and the date you returned the items.

- Be suspicious of anyone who offers you free genetic testing and then requests your Medicare number. If your personal information is compromised, it may be used in other fraud schemes.

- A physician that you know and trust should approve any requests for genetic testing.

- Medicare beneficiaries should be cautious of unsolicited requests for their Medicare numbers. If anyone other than your physician’s office requests your Medicare information, do not provide it.

- If you suspect Medicare fraud, contact the HHS OIG Hotline at https://oig.hhs.gov/fraud/report-fraud/.

For Home Health and Hospice Providers

MLN Connects® Weekly News

The MLN Connects® is the official news from the Medicare Learning Network and contains a weeks worth of Medicare-related messages. These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. The following provides access to the weekly messages. Please share with appropriate staff. If you wish to receive the listserv directly from CMS, refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.


For Home Health and Hospice Providers

MM11298: July 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.2

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles

MLN Matters Number: MM11298  Related Change Request (CR) Number: 11298
Related CR Release Date: May 24, 2019  Effective Date: July 1, 2019
Related CR Transmittal Number: R4314CP  Implementation Date: July 1, 2019

Provider Type Affected

This MLN Matters Article is for providers and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.
**Provider Action Needed**

CR11298 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications.

For the Integrated OCE that Medicare uses:

- Under the Outpatient Prospective Payment System (OPPS)
- For Non-OPPS hospital outpatient departments, community mental health centers and all non-OPPS providers
- For limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System
- For a hospice patient for the treatment of a non-terminal illness.

Make sure your billing staffs are aware of these changes.

**Background**

CR11298 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for July 1, 2019. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The Centers for Medicare & Medicaid Services (CMS) will post the I/OCE specifications at [http://www.cms.gov/OutpatientCodeEdit/](http://www.cms.gov/OutpatientCodeEdit/).

The table below summarizes the modifications of the I/OCE for the July 2019 V20.2 release is summarized in the table below. Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. CMS has added some I/OCE modifications in the update retroactively to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2012</td>
<td>6</td>
<td>Implement logic to return edit 6 if an invalid procedure code is submitted on a 770-bill type.</td>
</tr>
<tr>
<td>10/1/2012</td>
<td>48, 9</td>
<td>Update the valid revenue table and apply conditions for revenue code 760 to bypass edit 48 and instead apply edit 9, if a blank HCPCS is submitted using this revenue code.</td>
</tr>
<tr>
<td>1/1/2018</td>
<td>41</td>
<td>Update the effective date for the revenue codes 870, 871, 872, 873, 874, 875, and 891.</td>
</tr>
<tr>
<td>1/1/2018</td>
<td>111</td>
<td>Implement new edit 111: Service cost is duplicative; included in cost of associated biological. (Line Item Rejection (LIR)) Edit Criteria: A claim is submitted with a procedure (HCPCS) identified as being bundled into the cost of a biological or a blank HCPCS is submitted with revenue code 870-873 (Cell/ Gene Therapy). See Special Processing of Drugs and Biologicals logic section of I/OCE documentation.</td>
</tr>
<tr>
<td>1/1/2019</td>
<td></td>
<td>Implement logic to allow certain wound care services identified as being “sometimes therapy” to be excluded from comprehensive APC packaging if the conditions are present for changing the Status Indicator (SI) to A. See logic sections “Sometimes Therapy Processing for Wound Care Services” and Comprehensive APC Assignment Criteria for more information.</td>
</tr>
<tr>
<td>7/1/2019</td>
<td></td>
<td>Add new Input Payer Value Code: QA: Offset for combining Partial Hospitalization Program (PHP) week on interim PHP claim Add new Payer Condition Codes: MV: Second portion of combined PHP week is not 20 hours MW: First portion of combined PHP week is not 20 hours</td>
</tr>
<tr>
<td>7/1/2019</td>
<td></td>
<td>Update effective date of Value Code and Value Code Amount QW 000000000 to return if an interim PHP claim has a partial week present. (July 1, 2019)</td>
</tr>
<tr>
<td>7/1/2019</td>
<td></td>
<td>Implement logic to accept Payer Value Code and Value Code Amount QA 000000000 on input to identify that the previous Partial Hospitalization Program (PHP) claim had a partial last week that needs to be combined into the first week of the processing claim to calculate one full week of services (7 days). The Value Code Amount represents the amount of days and hours of PHP services that were on the previous claims partial last week. See Partial Hospitalization Logic section for more information.</td>
</tr>
</tbody>
</table>
### Effective Date | Edits Affected | Modification
--- | --- | ---
7/1/2019 | 95 | Implement logic to return Payer Condition Code MV if the combined partial weeks (first and second portion equal 7 days) is not 20 hours. Note: MV is returned on the second interim claim based on the input of Payer Value Code and Value Code Amount QA 000000000. Additionally, line items submitted on the second portion of the combined PHP week return edit 95 if the combined week is not 20 hours. See Partial Hospitalization Logic section for more information.

7/1/2019 | 95 | Implement logic to accept Condition Code MW on input, indicating that after combining the partial weeks together, 20 hours of services were not provided and the first portion of the combined week needs editing. All line items associated with the partial last week on the initial claim return edit 95. See Partial Hospitalization Logic section for more information.

7/1/2019 | Update logic to return Payer Condition Code MQ if an admission to discharge claim (761 or 131 CC 41) or an interim to discharge claim (764 or 134 CC 41) is submitted and the last 7-day week on the claim is not 20 hours. See Partial Hospitalization Logic section for more information.

7/1/2019 | Update description of Claim Processed Flag value of 4
4 - Fatal error; claim could not be processed as input values are not valid or are incorrectly formatted; exit immediately.

7/1/2019 | Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
- Add-on Type I (edit 106)
- Add-on Type II (edit 107)
- Comprehensive Ambulatory Payment Classification (APC) rank and list update
- Device and Device Procedure lists (edit 92)
- Terminated Device Procedure for offset APC
- Edit 99 Exclusions list
- FQHC Flu PPV list
- FQHC Non-Covered list
- Skin Substitute Hi and Low-Cost lists (edit 87)
- Not recognized by OPPS (edit 62)
- Valid Revenue Code list (edit 41)

7/1/2019 | Implement version 25.2 of the NCCI (as modified for applicable outpatient institutional providers).

### Additional Information

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

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

### Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 31, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

### For Home Health and Hospice Providers

**MM11318: July 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles

**MLN Matters Number:** MM11318  **Related Change Request (CR) Number:** 11318
**Related CR Release Date:** May 24, 2019  **Effective Date:** July 1, 2019
**Related CR Transmittal Number:** R4313CP  **Implementation Date:** July 1, 2019

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters are available at no cost from our website at https://www.cgsmedicare.com. © 2019 Copyright, CGS Administrators, LLC.
Provider Type Affected
This MLN Matters Article is intended for hospital outpatient facilities, physicians, providers, including home health and hospice providers, and suppliers billing Medicare Administrative Contractors (MACs) for hospital outpatient services provided to Medicare beneficiaries.

Provider Action Needed
CR11318 describes changes to and billing instructions for various payment policies implemented in the July 2019 OPPS update. Make sure your billing staffs are aware of these changes.

Background
This article describes changes to and billing instructions for various payment policies implemented in the July 2019 OPPS update. The July 2019 Integrated Outpatient Code Editor (I/OCE) will reflect the HCPCS, Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicator (SI), and Revenue Code additions, changes, and deletions identified in CR11318.

1. New Temporary C-Code

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9756</td>
<td>Fluorescence lymph map w/ ICG</td>
<td>Intraoperative near-infrared fluorescence lymphatic mapping of lymph node(s) (sentinel or tumor draining) with administration of indocyanine green (ICG) (List separately in addition to code for primary procedure)</td>
<td>NA</td>
<td>N</td>
</tr>
</tbody>
</table>

2. New CPT Category III Codes Effective July 1, 2019

Similar to the vaccine codes, the American Medical Association (AMA) releases the CPT Category III codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

For the July 2019 update, The Centers for Medicare & Medicaid Services (CMS) is implementing 20 CPT Category III codes that the AMA released in January 2019 for implementation on July 1, 2019. The codes, their SIs and APC assignments are included in Table 2, below. Also added to the July 2019 Addendum B, posted on the CMS website, effective July 1, 2019, are CPT codes 0543T through 0562T. These codes were also added to the July I/OCE update. However, CPT codes 0559T and 0561T were added to the July I/OCE with status indicator “S”. Their status indicators would be changed to status indicator “Q1” retroactive to July 1, 2019, in the October I/OCE update. These codes, along with their short descriptors, SIs, and payment rates (where applicable) are also listed in the July 2019 OPPS Addendum B that is available at [https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/addendum-a-and-addendum-b-updates.html](https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/addendum-a-and-addendum-b-updates.html). For information on the OPPS SIs, refer to OPPS Addendum D1 of the CY 2019 OPPS/ASC final rule for the latest definitions at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html).

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0543T</td>
<td>Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>0544T</td>
<td>Transcatheter mitral valve annulus reconstruction, with implantation of adjustable annulus reconstruction device, percutaneous approach including transseptal puncture</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>0545T</td>
<td>Transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>0546T</td>
<td>Radiofrequency spectroscopy, real time, intraoperative margin assessment, at the time of partial mastectomy, with report</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>
### Table 2. — CPT Category III Codes Effective July 1, 2019

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0547T</td>
<td>Bone-material quality testing by microindentation(s) of the tibia(s), with results reported as a score</td>
<td>E1</td>
<td></td>
</tr>
<tr>
<td>0548T*</td>
<td>Transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy</td>
<td>J1</td>
<td>5377</td>
</tr>
<tr>
<td>0549T</td>
<td>Transperineal periurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy</td>
<td>J1</td>
<td>5375</td>
</tr>
<tr>
<td>0550T</td>
<td>Transperineal periurethral balloon continence device; removal, each balloon</td>
<td>J1</td>
<td>5374</td>
</tr>
<tr>
<td>0551T</td>
<td>Transperineal periurethral balloon continence device; adjustment of balloon(s) fluid volume</td>
<td>T</td>
<td>5371</td>
</tr>
<tr>
<td>0552T</td>
<td>Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>0553T</td>
<td>Percutaneous transcatheter placement of iliac arteriovenous anastomosis implant, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention</td>
<td>E1</td>
<td></td>
</tr>
<tr>
<td>0554T</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>0555T</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; retrieval and transmission of the scan data</td>
<td>S</td>
<td>5731</td>
</tr>
<tr>
<td>0556T</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; assessment of bone strength and fracture risk and bone mineral density</td>
<td>S</td>
<td>5523</td>
</tr>
<tr>
<td>0557T</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography scan; interpretation and report</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>0558T</td>
<td>Computed tomography scan taken for the purpose of biomechanical computed tomography analysis</td>
<td>S</td>
<td>5521</td>
</tr>
<tr>
<td>0559T</td>
<td>Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure</td>
<td>Q1</td>
<td>5733</td>
</tr>
<tr>
<td>0560T</td>
<td>Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>0561T</td>
<td>Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide</td>
<td>Q1</td>
<td>5733</td>
</tr>
<tr>
<td>0562T</td>
<td>Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

* HCPCS code C9746 (Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed), which was effective July 1, 2017, was deleted June 30, 2019, and replaced with CPT code 0548T effective July 1, 2019.

3. **CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective July 1, 2019**

The AMA CPT Editorial Panel deleted one PLA code, specifically, 0057U, and established 21 new PLA codes, specifically, CPT codes 0084U through 0104U, effective July 1, 2019. Table 3, below, lists the long descriptors and SIs for the codes.

For more information on OPPS status indicators “A,” “D,” “E1,” and “Q4,” refer to OPPS Addendum D1 of the Calendar Year 2019 OPPS/ASC final rule for the latest definitions. Added to the July 2019 I/OCE are CPT codes 0084U through 0104U with an effective date of July 1, 2019. These codes, along with their short descriptors and status indicators, are also listed in the July 2019 OPPS Addendum B.
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0057U</td>
<td>Oncology (solid organ neoplasia), mrna, gene expression profiling by massively parallel sequencing for analysis of 51 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a normalized percentile rank</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>0084U</td>
<td>Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>0085U</td>
<td>Cytotethal distending toxin B (CdtB) and vinculin IgG antibodies by immunoassay (i.e., ELISA)</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>0086U</td>
<td>Infectious disease (bacterial and fungal), organism identification, blood culture, using rRNA FISH, 6 or more organism targets, reported as positive or negative with phenotypic minimum inhibitory concentration (MIC)-based antimicrobial susceptibility</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>0087U</td>
<td>Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>0088U</td>
<td>Transplantation medicine (kidney allograft rejection), microarray gene expression profiling of 1494 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score for rejection</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>0089U</td>
<td>Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>0090U</td>
<td>Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a categorical result (ie, benign, indeterminate, malignant)</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>0091U</td>
<td>Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result</td>
<td>E1</td>
<td></td>
</tr>
<tr>
<td>0092U</td>
<td>Oncology (lung), three protein biomarkers, immunoassay using magnetic nanosensor technology, plasma, algorithm reported as risk score for likelihood of malignancy</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>0093U</td>
<td>Prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>0094U</td>
<td>Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>0095U</td>
<td>Inflammation (eosinophilic esophagitis), ELISA analysis of eosetoxi (CCL26 [C-C motif chemokine ligand 26]) and major basic protein (PRG2 [proteoglycan 2, pro eosinophil major basic protein]), specimen obtained by swallowed nylon string, algorithm reported as predictive probability index for active eosinophilic esophagitis</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>0096U</td>
<td>Human papillomavirus (HPV), high-risk types (ie, 16, 18, 31, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68), male urine</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>0097U</td>
<td>Gastrointestinal pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 22 targets (Campylobacter [C. jejuni/C. coli/C. upsaliensis], Clostridium difficile [C. difficile] toxin A/B, Plesiomonas shigelloides, Salmonella, Vibrio [V. parahaemolyticus/V. vulnificus/V. cholerae], including specific identification of Vibrio cholerae, Yersinia enterocolitica, Enteraggregative Escherichia coli [EAEC], Enteropathigenic Escherichia coli [EPEC], Enterotoxigenic Escherichia coli [ETEC] It/tst, Shiga-like toxin-producing Escherichia coli [STEC] stx1/stx2 [including specific identification of the E. coli O157 serogroup within STEC], Shigella/ Enteroinvasive Escherichia coli [EIEC], Cryptosporidium, Cyclospora cayetanensis, Entamoeba histolytica, Giardia lamblia [also known as G. intestinalis and G. duodenalis], adenovirus F 40/41, astrovirus, norovirus G/I/GII, rotavirus A, sapovirus [Genogroups I, II, IV, and V])</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>0098U</td>
<td>Respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 14 targets (adenovirus, coronavirus, human metapneumovirus, influenza A, influenza A subtype H1, influenza A subtype H3, influenza A subtype H1-2009, influenza B, parainfluenza virus, human rhinovirus/ enterovirus, respiratory syncytial virus, Bordetella pertussis, Chlamydia pneumoniae, Mycoplasma pneumoniae)</td>
<td>Q4</td>
<td></td>
</tr>
</tbody>
</table>
Table 3. — PLA Coding Changes Effective July 1, 2019

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0099U</td>
<td>Respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 20 targets (adenovirus, coronavirus 229E, coronavirus HKU1, coronavirus, coronavirus OC43, human metapneumovirus, influenza A, influenza A subtype, influenza A subtype H3, influenza A subtype H1-2009, influenza, parainfluenza virus, parainfluenza virus 2, parainfluenza virus 3, parainfluenza virus 4, human rhinovirus/enterovirus, respiratory syncytial virus, Bordetella pertussis, Chlamydia pneumonia, Mycoplasma pneumoniae)</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>0100U</td>
<td>Respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 21 targets (adenovirus, coronavirus 229E, coronavirus HKU1, coronavirus NL63, coronavirus OC43, human metapneumovirus, human rhinovirus/enterovirus, influenza A, including subtypes H1, H1-2009, and H3, influenza B, parainfluenza virus 1, parainfluenza virus 2, parainfluenza virus 3, parainfluenza virus 4, respiratory syncytial virus, Bordetella parapertussis [IS1001], Bordetella pertussis [ptxP], Chlamydia pneumoniae, Mycoplasma pneumoniae)</td>
<td>Q4</td>
<td></td>
</tr>
<tr>
<td>0101U</td>
<td>Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (15 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>0102U</td>
<td>Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and deletion/duplication])</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>0103U</td>
<td>Hereditary ovarian cancer (eg, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], EPCAM [deletion/duplication only])</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>0104U</td>
<td>Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (32 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])</td>
<td>A</td>
<td></td>
</tr>
</tbody>
</table>

Table 4. — CPT Category III Codes Effective July 1, 2019

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0541T</td>
<td>Myocardial imaging by magnetocardiography (mccg) for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study;</td>
<td>S</td>
<td>5722</td>
</tr>
</tbody>
</table>

4. **Myocardial Imaging by Magnetocardiography (MCG)**

Currently, CPT codes 0541T and 0542T are SI “E1.” This indicates that the codes are not paid by Medicare, when submitted on outpatient claims (any outpatient bill type). On March 15, 2019, the device associated with these codes, specifically, the CardioFlux Magnetocardiography (MCG), received FDA approval. Consequently, CMS is revising the SIs for CPT codes 0541T and 0542T. Specifically, CMS is re-assigning CPT code 0541T from “E1” to “S” (Procedure or Service, Not Discounted When Multiple. Paid under OPPS; separate APC payment.) and assigning it to APC 5722 (Level 2 Diagnostic Tests and Related Services). Also, we are re-assigning CPT code 0542T from “E1” to “M” (Items and Services Not Billable to the MAC, not paid under OPPS.) effective July 1, 2019. The payment rate for CPT code 0541T is listed in Addendum B of the July 2019 OPPS Update that is posted on the CMS website. Listed in table 4 below are CPT codes 0541T and 0542T and their status indicators.
5. Drugs, Biologicals, and Radiopharmaceuticals

a. New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For July 2019, six new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 5. Also, HCPCS code Q5107 (Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg) is currently not being marketed, so pricing information is not available for the July OPPS quarterly release. Once Q5107 is on the market, CMS will make pricing information available at the soonest possible date on the OPPS payment files and payment will be retroactive to the date the product is first available.

b. New Established HCPCS Codes for Separately Payable Drugs and Biologicals as of July 1, 2019

On July 1, 2019, nine new separately payable drug and biological HCPCS codes are established. Six of the codes are new codes. HCPCS code J9036 will replace HCPCS code C9042. Another HCPCS code J7208, will replace HCPCS code C9141. HCPCS code J9030 will replace HCPCS code J9031. The new codes are in Table 6. HCPCS codes C9042, C9141, and J9031 will be deleted effective June 30, 2019.
c. Descriptor Change for the HCPCS code J9355, Effective July 1, 2019

Effective July 1, 2019, the descriptors for the HCPCS code J9355 were updated. Please see table 7.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Old Short Descriptor</th>
<th>New Short Descriptor</th>
<th>Old Long Descriptor</th>
<th>New Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9355</td>
<td>Trastuzumab injection</td>
<td>Inj trastuzumab excl</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>biosimi</td>
<td>Injection, trastuzumab, 10 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Injection, trastuzumab, excludes biosimilar, 10 mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

d. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

For CY 2019, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals that were not acquired through the 340B Program is made at a single rate of ASP + 6 percent (or ASP - 22.5 percent if acquired under the 340B Program), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2019, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. CMS updates payments for drugs and biologicals based on ASPs on a quarterly basis as later quarter ASP submissions become available. Effective July 1, 2019, payment rates for some drugs and biologicals have changed from the values published in the April 2019 update of the OPPS Addendum A and Addendum B found on the CMS web site. CMS is not publishing the updated payment rates in this CR implementing the July 2019 update of the OPPS. However, the updated payment rates effective July 1, 2019, are in the July 2019 update of the OPPS Addendum A and Addendum B at [http://www.cms.gov/HospitalOutpatientPPS/](http://www.cms.gov/HospitalOutpatientPPS/).

e. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at [https://www.cms.gov/Medicare/Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html). Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

6. Reassignment of Skin Substitute Products from the Low-Cost Group to the High Cost Group

One skin substitute product, HCPCS code Q4176, was reassigned from the low-cost skin substitute group to the high-cost skin substitute group based on updated pricing information. The product is in Table 8.

<table>
<thead>
<tr>
<th>CY 2019 HCPCS Code</th>
<th>CY 2019 Short Descriptor</th>
<th>CY 2019 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4176</td>
<td>Neopatch, per square centimeter</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

7. New CPT Category I Vaccine Code Effective July 1, 2019

The AMA releases CPT Category I vaccine codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

For the July 2019 update, CMS is implementing one CPT Category I vaccine code that the AMA released in January 2019 for implementation on July 1, 2019. The SI for
the code is shown in Table 9. For more information on the OPPS Status Indicator (SI) “E1,” refer to OPPS Addendum D1 of the CY 2019 OPPS/ASC final rule for the latest definitions. CPT code 90619 is included in the July 2019 I/OCE with an effective date of July 1, 2019. CPT code 90619, along with its short descriptor and status indicator, is also listed in the July 2019 OPPS Addendum B.

Table 9. — CPT Category I Vaccine Code Effective July 1, 2019

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>90619</td>
<td>Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use</td>
<td>E1</td>
<td></td>
</tr>
</tbody>
</table>

8. **Status Indicator Revision for CPT Code 90689**

Currently, CPT code 90689 has SI to “E1” to indicate that the vaccine is not payable by Medicare when submitted on outpatient claims (any outpatient bill type). However, as noted in Change Request 10871 (Quarterly Influenza Virus Vaccine Code Update - January 2019), Transmittal 4141, dated September 27, 2018, effective for claims with dates of service on or after January 1, 2019, CPT 90689 will be payable by Medicare. Therefore, we are revising the SI from “E1” to “L” for CPT code 90689 to indicate that the vaccine will be “Paid at reasonable cost; not subject to deductible or coinsurance” retroactive to January 1, 2019. Refer to Table 10 for the code long descriptor and SI assignment. For more information on OPPS status indicators “E1” and “L,” refer to OPPS Addendum D1 of the Calendar Year 2019 OPPS/ASC final rule for the latest definitions. To access transmittal 4141, refer to https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4141CP.pdf.

Table 10. — CPT Code 90689 Status Indicator Revision

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>90689</td>
<td>Influenza virus vaccine, quadrivalent (iiv4), inactivated, adjuvanted, preservative free, 0.25 ml dosage, for intramuscular use</td>
<td>L</td>
<td></td>
</tr>
</tbody>
</table>

9. **Status Indicator Revision for HCPCS Code A4563**

Currently, A4563 is assigned to SI “N” (Paid under OPPS; payment is packaged into payment for other services). Therefore, there is no separate APC payment. However, CMS is revising the SI to “A” (Not paid under OPPS but paid by MACs under a fee schedule or payment system other than OPPS.) effective January 1, 2019. In the July 2019, I/OCE update since the code is separately payable under the Durable Medical Equipment, Prosthetics/Orthotics & Supplies (DMEPOS) Fee Schedule you may refer to Table 11 for the code long descriptor and SI for HCPCS code A4563.

Table 11. — HCPCS Code A4563 Status Indicator Revision

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4563</td>
<td>Rectal control system for vaginal insertion, for long term use, includes pump and all supplies and accessories, any type each</td>
<td>A</td>
<td></td>
</tr>
</tbody>
</table>

10. **OPPS Pricer logic and data changes for July**

There are no OPPS PRICER logic or data changes for July; therefore, there is no OPPS PRICER release for July.

11. **Coverage Determinations**

As a reminder, the fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether or not it is payable.
Additional Information

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

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>May 30, 2019</td>
<td>Initial article released.</td>
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</table>

For Home Health and Hospice Providers

**MM11321: 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

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles

<table>
<thead>
<tr>
<th>MLN Matters Number: MM11321</th>
<th>Related Change Request (CR) Number: 11321</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Release Date: June 7, 2019</td>
<td>Effective Date: October 1, 2019</td>
</tr>
<tr>
<td>Related CR Transmittal Number: R4317CP</td>
<td>Implementation Date: October 7, 2019</td>
</tr>
</tbody>
</table>

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
CR11321 instructs MACs and Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform use of Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Claim Adjustment Group Code (CAGC) rule publication. These system updates are based on the CORE Code Combination List, which will be published on or about June 4, 2019. Make sure that 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) Committee on Operating Rules for Information Exchange (CORE), Electronic Funds Transfer (EFT), and Electronic Remittance
Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act (the Act) by adding Part C—Administrative Simplification—to Title XI that required the Secretary of DHHS to adopt standards for certain transactions to enable more efficient health information exchange and uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote the implementation of electronic transactions and to achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. Congress accomplished this by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines the operating rules and specifies the role of operating rules in relation to the standards.

CR11321 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 June 4, 2019. This update is based on the CARC and RARC updates the Washington Publishing Company (WPC) posts on its website on or about March 1, 2019. This will also include industry needed updates that are based on a market-based review that CAQH CORE conducts once a year to accommodate code combinations that health plans (including Medicare) are currently using.


**Note:** The Affordable Care Act mandates that 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 (4) business scenarios. Medicare can use any code combination if the business scenario is not one of the four (4) CORE defined business scenarios. With the four (4) CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

**Additional Information**


If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

**Document History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>June 10, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

**For Home Health and Hospice Providers**

**New FISS Reason Code Search and Resolution Feature**

reasoncodes.asp has been designed to aid Medicare Home Health providers in reviewing specific Fiscal Intermediary Standard System (FISS) reason codes and how to resolve the edit. The feature is searchable by reason code or keyword and is located on the Claims left side navigation menu, the Self-Service Options page at https://www.cgsmedicare.com/hhh/tools/index.html and the Educational Materials & Resources Web page at https://www.cgsmedicare.com/hhh/education/materials/index.html. Try it!

For Home Health and Hospice Providers

New Home Health and Hospice Video Education

CGS is excited to share new video education developed for new Medicare providers and clinical home health staff. Refer to the Video Education Web page at https://www.cgsmedicare.com/hhh/education/video.html to access the following video education at your leisure.

- **Home Health & Hospice New Provider Resource Center Videos** – Three videos introduce providers to the listserve notification services offered by CGS and CMS, common websites, electronic billing, Calendar of Events, and the Medicare Bulletin.
- **Frequently Asked Questions** – This video is geared towards home health clinical questions and answers that include face-to-face requirements and information about the plan of care (e.g. 485).

The Video Education Web page also includes other videos related to myCGS, the targeted probe and educate (TPE) process, and eligibility.

For Home Health and Hospice Providers

Provider Contact Center (PCC) Training

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). The list below indicates when the home health and hospice PCC at 1.877.299.4500 (option 1) will be closed for training.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Training/Closures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday, August 8, 2019</td>
<td>8:00 a.m.– 10:00 a.m. Central Time</td>
</tr>
<tr>
<td>Thursday, August 22, 2019</td>
<td>8:00 a.m.– 10:00 a.m. Central Time</td>
</tr>
</tbody>
</table>

The Interactive Voice Response (IVR) (1.877.220.6289) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at https://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf on the CGS website. In addition, CGS' Internet portal, myCGS, is available to access eligibility information through the Internet. For additional information, go to https://www.cgsmedicare.com/hhh/index.html and click the “myCGS” button on the left side of the webpage.

For Home Health and Hospice Providers

Take Action Now: Home Health & Hospice Providers FISS DDE User ID Annual Recertification

Each year, Medicare providers are required to recertify their Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) user access. The recertification period for home health and hospice providers begins July 1, 2019. Please review the information under the “What You Need to Do” heading. Failure to recertify will result in the termination of FISS DDE/PPTN services.

What You Need to Do

- Complete the Annual DDE PPTN Recertification Form at https://www.cgsmedicare.com/forms/annual_dde_pptn_recert_formRE.pdf as soon as possible. Verify all User IDs, indicate if the User ID is active or inactive, and include an authorized signature, contact email, and phone number.

  **Note:** This form is not used to add new users, delete users, or to update current users. To add, delete, or update User ID information, you must complete an Online Inquiry Services form at https://www.cgsmedicare.com/pdf/J15_EDI_OnlineInquiry2015re.pdf. This form is not used for myCGS Recertification.

- FAX the Annual DDE PPTN Recertification Form starting July 1, 2019 to CGS at: 1.615.664.5947

**Hospice Providers:** Please be aware that failure to recertify your FISS DDE access will result in the termination of your DDE User ID. This may cause untimely filing of your hospice Notices of Election (NOEs) and an exception may not be granted.

If you have any questions concerning the DDE recertification process, please contact the CGS J15 EDI department at 1.877.299.4500 and select Option 2.

For Home Health and Hospice Providers

Upcoming Educational Events

The CGS Provider Outreach and Education (POE) department offers educational events through webinars and teleconferences throughout the year. Registration for these events is required. For upcoming events, please refer to the Calendar of Events Home Health & Hospice Education Web page at https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/HHH_Report.asp. CGS suggests that you bookmark this page and visit it often for the latest educational opportunities.

If you have a topic that you would like the CGS POE department to present, send us your suggestion to J15_HHH_Education@cgsadmin.com.

For Home Health and Hospice Providers

Update to the Interest Paid on Clean Non-PIP Claims Not Paid Timely

According to the *Medicare Claims Processing Manual*, (Pub 100-04, Ch. 1., §80.2.2), interest is paid on clean claims, not paid under the periodic interim payment (PIP) method, if payment is not made within 30 days after the date of receipt. The interest rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. Effective, July 1, 2019, the interest amount is 2.625%.
Note: Interest is not paid on home health prospective payment system (HH PPS) request for anticipated payment (RAP) billing transactions.