**HOME HEALTH PROVIDERS**

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FOR HOME HEALTH PROVIDERS

MM11527: Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions

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/index

MLN Matters Number: MM11527
Related CR Release Date: November 8, 2019
Related CR Transmittal Number: R4452CP
Related Change Request (CR) Number: 11527
Effective Date: January 1, 2020
Implementation Date: December 11, 2019

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Home Health & Hospice Medicare Administrative Contractors (HH&H MACs) for services to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11527 informs Medicare contractors about the revisions to additional sections of Chapter 10 of the Medicare Claims Processing Manual to support implementation of the Home Health (HH) Patient-Driven Groupings Model (PDGM). Make sure that your billing staffs are aware of these changes.

BACKGROUND

In the Calendar Year (CY) 2019 final HH Prospective Payment System (PPS) Rate Update final rule, the Centers for Medicare & Medicaid Services (CMS) finalized an alternative case-mix methodology now called the PDGM, which includes payment reform requirements as set forth in the Bipartisan Budget Act (BBA) of 2018. These payment reform requirements will be implemented in CY 2020. The manual instructions in CR 11527 are revised to conform to the final policies of the PDGM.

CR 11527 further implements the policies of the PDGM, as described in the CY 2019 HH final rule and as required by Section 51001 of the BBA of 2018. For the complete policy, see the final rule and CRs 11081, 11272 and 11395.

Note: You can review the articles related to these CRs at the following locations:

The following summarizes the manual changes:

1. **Inpatient Stays Spanning the End of a 30-day Period**
   Discharge should be made at the end of the 60-day certification period in all cases if the beneficiary has not returned to the HHA. If the beneficiary returns to HH after an inpatient stay that spans the end of the certification period, Medicare requires a new start of care assessment and a Request for anticipated Payment (RAP) and claim with a new admission date.

   For services after January 1, 2020, discharge is not required if the beneficiary has an inpatient stay that spans the end of the first 30-day period of care in a certification period. The HHA should submit the RAP and claim for the period following the discharge as if the 30-day periods were contiguous – submit a From date of day 31, even though it falls during the inpatient stay and the first visit date that occurs after the hospital discharge. Medicare systems will allow the HH claim to overlap the inpatient claim for dates in which there are no HH visits.

2. **Periods of Care with No Visits Expected - Service Date on Requests for Anticipated Payment (RAPs)**
   On RAPs for initial periods of care, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode/period. For subsequent periods of care, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode/period, regardless of whether the visit was covered or non-covered.

   The one exception to reporting a visit date on the 0023 revenue code of the RAP is when no visits are expected during a 30-day period of care. For instance, if the beneficiary’s plan of care requires that the beneficiary is seen every 6 weeks and there is a recertification, the beneficiary might receive no visits in the first 30-day period following the recertification. In this case, the HHA should submit a RAP for all 30-day periods, but only submit claims for 30-day periods in which visits were delivered.

   If no visits are expected during an upcoming 30-day period, the HHA should submit the RAP with the first day of the period of care as the service date on the 0023 line. The RAP for a period with no visit will ensure the HHA remains recorded on Medicare’s Common Working File (CWF) system as the primary HHA for the beneficiary and will ensure that HH consolidated billing is enforced. If no visits are provided, the RAP will later be auto-cancelled to recover the payment.

**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 of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 12, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
For Home Health Providers

MM11532: 2020 Annual Update of Per-Beneficiary Threshold Amounts

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/index

MLN Matters Number: MM11532
Related CR Release Date: October 25, 2019
Related CR Transmittal Number: R4419CP
Related Change Request (CR) Number: 11532
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

Provider Type Affected

This MLN Matters Article is intended for physicians, therapists, and other providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider Action Needed

CR 11532 updates the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for CY 2020. These amounts were previously associated with the financial limitation amounts that were more commonly referred to as “therapy caps” before the Bipartisan Budget Act of 2018 was signed into law repealing the application of the caps.

For CY 2020, the KX modifier threshold amounts are: (a) $2,080 for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined, and (b) $2,080 for Occupational Therapy (OT) services. Make sure your billing staffs are aware of these updates.

Background

Section 50202 of the Bipartisan Budget Act of 2018, P.L. 115-123 (BBA of 2018) amended Section 1833(g) of the Social Security Act (the Act) to repeal the application of the therapy caps while also retaining and adding limitations to ensure appropriate therapy.

A provision of Section 50202 of the BBA of 2018 adds Section 1833(g)(7)(A) of 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; and, there is one amount for PT and SLP services combined and a separate amount for OT services. Medicare will deny your claims for therapy services above these amounts without the KX modifier.

These per-beneficiary amounts under Section 1833(g) of the Act (as amended by 1997 BBA) are updated each year by the Medicare Economic Index (MEI). For CY 2020, the KX modifier threshold amounts are: (a) $2,080 for PT and SLP services combined, and (b) $2,080 for OT services.

Another provision of Section 50202 of the BBA of 2018 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. This threshold amount is now termed the Medical Record (MR) threshold amount – one MR threshold amount for PT and SLP services combined and another for OT services – remains at $3,000 until CY 2028 at which time it will be updated by the MEI.
ADDITIONAL INFORMATION
The official instruction, CR11532, issued to your MAC regarding this change is available at

If you have questions, your MACs may have more information. Find their website

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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</thead>
<tbody>
<tr>
<td>November 12, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

FOR HOME HEALTH PROVIDERS

MM11536: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020

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/index

MLN Matters Number: MM11536
Related CR Release Date: November 8, 2019
Related CR Transmittal Number: R4453CP
Related Change Request (CR) Number: 11536
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

PROVIDER TYPES AFFECTED
This MLN Matters Article is intended for Home Health Agencies (HHAs) billing Medicare
Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW
Change Request (CR) 11536 updates the CY 2020 60-day and 30-day base payment rates, the
national per-visit amounts, Low-Utilization Payment Adjustment (LUPA) add-on amounts, the
non-routine medical supply payment amounts, and the cost-per-unit payment amounts used for
calculating outlier payments under the HH PPS. In addition, this CR revises the initial payment
percentage for both initial and subsequent 30-day periods of care under the split percentage
payment approach for CY 2020. Make sure that your billing staffs are aware of these changes.

BACKGROUND
The Medicare HH Prospective Payment System (HH PPS) rates provided to HH agencies
(HHAs) for furnishing HH services are updated annually as required by Section 1895(b)(3)(B) of
the Social Security Act (the Act). The CY 2020 HH PPS rate update includes implementation of
the Patient-Driven Groupings Model (PDGM), a revised case-mix adjustment methodology for
HH services beginning on or after January 1, 2020.

The CY 2020 HH PPS rate update implements a change in the unit of payment from a 60-day
episode of care to a 30-day period of care as required by Section 1895(b)(2)(B) of the Act, as
amended by Section 51001(a)(1) of the Bipartisan Budget Act (BBA) of 2018. This rate update
will increase the CY 2020 60-day and 30-day base payment rates by the appropriate rural
add-on percentage prior to applying any case-mix and wage index adjustments, as required by
Section 421(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), as amended by Section 50208(a) of the BBA of 2018.

Finally, in CY 2020, for existing HHAs (that is, HHAs certified for participation in Medicare with effective dates prior to January 1, 2019), the split-percentage payment will be reduced from the current 60/50 percent (dependent on whether the request for anticipated payment (RAP) is for an initial or subsequent period of care) to 20 percent in CY 2020 for all 30-day HH periods of care (both initial and subsequent periods of care).

Newly-enrolled HHAs (that is, HHAs certified for participation in Medicare effective on or after January 1, 2019), will not receive split-percentage payments for CY 2020 but are required to submit “no-pay” RAPs for all 30-day HH periods of care.

Market Basket Update
Section 53110 of the BBA of 2018 amended Section 1895(b)(3)(B) of the Act, such that for HH payments for CY 2020, the HH payment update is required to be 1.5 percent. The multifactor productivity (MFP) adjustment is not applied to the BBA of 2018 mandated 1.5 percent payment update. Section 1895(b)(3)(B) of the Act requires that the HH payment update be decreased by 2 percentage points for those HHAs that do not submit quality data as required by the Secretary. For HHAs that do not submit the required quality data for CY 2020, the HH payment update would be -0.5 percent (1.5 percent minus 2 percentage points).

National, Standardized 60-Day Episode Payment and 30-Day Period Payment Amounts
As finalized in the CY 2019 HH PPS final rule, the unit of HH payment will change from a 60-day episode to a 30-day period effective for those 30-day periods beginning on or after January 1, 2020. The standardized 60-day payment rate will apply to case-mix adjusted episodes (that is, not low-utilization payment adjustments (LUPAs)) beginning on or before December 31, 2019, and ending on or after January 1, 2020. As such, the latest date a 60-day crossover episode could end on is February 28, 2020. Those 60-day episodes that begin on or before December 31, 2019, but are LUPA episodes, will be paid the national, per-visit payment rates.

To determine the CY 2020 national, standardized 60-day episode payment rate for those 60-day episodes that span the implementation date of the PDGM and the change to a 30-day unit of payment, CMS applies a wage index budget neutrality factor of 1.0060 and the HH payment update percentage of 1.5 percent for HHAs that submit the required quality data and by 1.5 percent minus 2 percentage points, or -0.5 percent for HHAs that do not submit the required quality data. These two episode payment rates are shown in Tables 1 and 2.

<table>
<thead>
<tr>
<th>Table 1: CY 2020 National, Standardized 60-Day Episode Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2019 National, Standardized 60-Day Episode Payment</td>
</tr>
<tr>
<td>$3,154.27</td>
</tr>
</tbody>
</table>

To determine the CY 2020 national, standardized 30-day period payment rate beginning January 1, 2020, CMS applies a wage index budget neutrality factor of 1.0063 and the HH payment update percentage of 1.5 percent for HHAs that submit the required quality data and by 1.5 percent minus 2 percentage points, or -0.5 percent for HHAs that do not submit the required quality data. These two episode payment rates are shown in Tables 3 and 4.

<table>
<thead>
<tr>
<th>Table 2: CY 2020 National, Standardized 60-Day Episode Payment Amount for HHAS that Do Not Submit the Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2019 National, Standardized 60-Day Episode Payment</td>
</tr>
<tr>
<td>$3,154.27</td>
</tr>
</tbody>
</table>
The payments for both the CY 2020 national, standardized 60-day episode payment rate and the CY 2020 national, standardized 30-day period payment rate are further adjusted by the individual episode’s case-mix weight and by the applicable wage index.

**National Per-Visit Rates**

In order to calculate the CY 2020 national per-visit payment rates, CMS starts with the CY 2019 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0066 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2020 wage index. The per-visit rates are then updated by the CY 2020 HH payment update of 1.5 percent for HHAs that submit the required quality data and by 0.995 for HHAs that do not submit quality data. The per-visit rates are shown in Tables 5 and 6.

**Table 5: CY 2020 National Per-Visit Payment Amounts for HHAS**

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>CY 2019 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2020 HH Payment Update</th>
<th>CY 2020 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$66.34</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$67.78</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$234.82</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$239.92</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$161.24</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$164.74</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$160.14</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$163.61</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$146.50</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$149.68</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$174.06</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$177.84</td>
</tr>
</tbody>
</table>

**Table 6: CY 2020 National Per-Visit Payment Amounts for HHAS that Do Not Submit the Required Quality Data**

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>CY 2019 Per-Visit Rates</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2020HH Payment Update Minus 2 Percentage Points</th>
<th>CY 2020 Per-Visit Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$66.34</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$66.44</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$234.82</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$235.19</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$161.24</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$161.49</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$160.14</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$160.39</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$146.50</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$146.73</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$174.06</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$174.33</td>
</tr>
</tbody>
</table>

**Non-Routine Supply Payments**

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. In CY 2020, the NRS payment amounts apply to only those 60-day episodes that begin on or before December 31, 2019, but span the implementation of the PDGM and the 30-day unit of payment on January 1, 2020 (ending in CY 2020, on or before February 28, 2020). Under the PDGM, NRS payments are included in the 30-day base payment rate. To determine the CY 2020 NRS conversion factors,
CMS updates the CY 2019 NRS conversion factor by the CY 2020 HH payment update of 1.5 percent for HHAs that submit the required quality data and by 0.995 for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2020 payments for HHAs that do submit the required quality data is shown in Table 7. The payment amounts for the various NRS severity levels are shown in Table 8. The NRS conversion factor for CY 2020 payments for HHAs that do not submit quality data is shown in Table 9 and the payment amounts for the various NRS severity levels are shown in Table 10.

<table>
<thead>
<tr>
<th>Table 7: CY 2020 NRS Conversion Factor</th>
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</thead>
<tbody>
<tr>
<td>CY 2019 NRS Conversion Factor</td>
</tr>
<tr>
<td>----------------------------------</td>
</tr>
<tr>
<td>$54.20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 8: CY 2020 NRS Payment Amounts</th>
</tr>
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<tbody>
<tr>
<td>Severity Level</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 9: CY 2020 NRS Conversion Factor for HHAS that Do Not Submit the Required Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2019 NRS Conversion Factor</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td>$54.20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 10 - CY 2020 NRS Payment Amounts for HHAS that Do Not Submit the Required Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity Level</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
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<tr>
<td>4</td>
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<td>5</td>
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<tr>
<td>6</td>
</tr>
</tbody>
</table>

Rural Add-On Provision

In the CY 2019 HH PPS final rule (83 FR 56443), CMS finalized policies for the rural add-on payments for CY 2019 through CY 2022, in accordance with section 50208 of the BBA of 2018. The CY 2019 HH PPS proposed rule (83 FR 32373) described the provisions of the rural add-on payments, the methodology for applying the new payments, and outlined how CMS categorized rural counties (or equivalent areas) based on claims data, the Medicare Beneficiary Summary File and Census data.

CY 2020 HH PPS payments will be increased by 0.5 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the “High utilization” category. CY 2020 HH PPS payments will be increased by 3.0 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the “Low population density” category. CY 2020 HH PPS payments will be increased by 2.0 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the “All other” category.
The HH PRICER module, located within the CMS claims processing system, will increase the final CY 2020 60-day and 30-day base payment rates by the appropriate rural add-on percentage prior to applying any case-mix and wage index adjustments.

Outlier Payments

The fixed dollar loss (FDL) ratio and the loss-sharing ratio used to calculate outlier payments must be selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by section 1895(b)(5)(A) of the Act). Historically, CMS has used a value of 0.80 for the loss-sharing ratio which CMS believes, preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount. No changes were made to the loss-sharing ratio of 0.80 for CY 2020.

For CY 2020, the FDL ratio for 60-day episodes that span the implementation date of the PDGM will remain 0.51. The FDL ratio for 30-day periods of care in CY 2020 is 0.56. In the CY 2017 HH PPS final rule (81 FR 76702), CMS finalized changes to the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. This change in methodology allows for more accurate payment for outlier episodes, accounting for both the number of visits during an episode of care and also the length of the visits provided. Using this approach, CMS now converts the national per-visit rates into per 15-minute unit rates. These per 15-minute unit rates are used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. The cost-per-unit payment rates used for the calculation of outlier payments are in Table 11.

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>For HHAs that DO Submit the Required Quality Data</th>
<th>For HHAs that DO NOT Submit the Required Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average Minutes Per-Visit</td>
<td>CY 2020 Per-Visit Payment</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>63.0</td>
<td>$67.78</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>56.5</td>
<td>$239.92</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>47.1</td>
<td>$164.74</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>46.6</td>
<td>$163.61</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>44.8</td>
<td>$149.68</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>48.1</td>
<td>$177.84</td>
</tr>
</tbody>
</table>

Split Percentage Payment

Medicare makes a split percentage payment for most HH PPS episodes/periods. The first payment is in response to a Request for Anticipated Payment (RAP), and the last in response to a claim. Added together, the first and last payment equals 100 percent of the permissible payment for the episode. The current split percentage payments are 60/40 (for initial episodes of care) and 50/50 (for subsequent episodes of care).

For CY 2020, the split-percentage payment for existing HHAs will be reduced to 20 percent in CY 2020 for all 30-day HH periods of care (both initial and subsequent periods of care).

In the CY 2019 HH PPS final rule (83 FR 56628), CMS finalized that newly-enrolled HHAs, that is HHAs certified for participation in Medicare effective on or after January 1, 2019, will not receive split-percentage payments beginning in CY 2020. HHAs that are certified for participation in Medicare effective on or after January 1, 2019, will still be required to submit a “no pay” Request for Anticipated Payment (RAP) at the beginning of a period of care in order to establish the HH period of care, as well as every 30 days thereafter.
FOR HOME HEALTH PROVIDERS

SE19025: Home Health Agencies (HHAs) Urged to Establish Access to the Internet Quality Improvement and Evaluation System (iQIES) By December 23, 2019

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/index

MLN Matters Number: SE19025
Article Release Date: November 18, 2019
Related Change Request (CR) Number:
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

Special Edition (SE) article SE19025 notifies HHAs that they need to onboard to the Internet Quality Improvement and Evaluation System (iQIES) by establishing a Healthcare Quality Information System Access, Roles, and Profile System (HARP) account and selecting an iQIES role. Please see the Background and Additional Information sections for more on this topic.

Please note that failure to obtain access to iQIES by December 23rd will impact your agencies’ ability to submit assessment data needed for claims matching purposes after January 1, 2020. Claims that cannot be matched to assessments will be returned to the HHA, delaying Medicare payment.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is upgrading the current Quality Improvement and Evaluation System (QIES) to make the system more reliable, secure, accessible, and scalable. The enhanced system, referred to as iQIES, reduces provider burden and enhances CMS’ ability to serve customers.

The rollout of iQIES will not require providers or vendors to change current processes related to submission of data. However, iQIES will require a new user management system because

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Virtual Private Networks (VPNs) and CMSNet are no longer needed to access this system. All users will have to create an account and establish credentials in HARP, which is a secure identity management portal provided by CMS.

**REGISTERING FOR IQIES**

HHAs should be aware that the following steps are required to successfully register for iQIES:

1. Register in the HARP system at [https://harp.qualitynet.org/register/profile-info](https://harp.qualitynet.org/register/profile-info). HARP uses Experian to remotely verify a user’s identity by applying the data that a user provides, such as date of birth and social security number, to generate a list of personal questions for the user to answer to verify his or her identity.

   **Note:** Some users who attempt to register in HARP may receive an error message stating that their email address already exists. This most likely means that you have completed some level of identity proofing in the past and that you have an Enterprise Identity Management System (EIDM) account. If this is the case, you will need to login to HARP using your EIDM login information. If you don't remember your login information, you will need to contact the QualityNet Help Desk at [qnetsupport@hcqis.org](mailto:qnetsupport@hcqis.org), or call 1.866.288.8912.

2. After you register in the HARP system (or login if you are an EIDM user), you will be directed to set up two-factor authentication, which requires an extra layer of security, like something that you have (for example, a smart phone). If you are an EIDM user, you will then need to login to HARP a second time; this will ensure that you are able to access iQIES to request your role (see Step 3).

3. Request your role in iQIES by logging in to iQIES at [https://iqies.cms.gov](https://iqies.cms.gov) using your HARP User ID and password (EIDM login information if you are an EIDM user). Verify your account using two-factor authentication and then select, “Submit.”

   **Note:** For a better user experience, we recommend using Chrome or Firefox to access iQIES.

4. Select “Request User Role” on the Welcome to iQIES page. Table 1 below lists iQIES User Roles. There are four steps to request an iQIES role:

   a. Select the “User Category”

   b. Select a “User Role.”

      **Note:** If your organization has not yet selected and registered a Security Official, you will not be able to request a role. CMS requests HHAs establish at least two provider security officials for each facility that would be responsible for approving users to ensure a smooth transition.

   c. Select your Organization(s). Requests for the Vendor or Provider categories include the requirement to add one or more CMS Certification Numbers (CCNs). This enables access to those providers. As CCNs are entered, those providers are added to the list of permission requests. An error message will be displayed on the screen if you enter an invalid CCN.

   d. Once you provide all required data, select, “Submit Request.” A “Role Request Submitted” message will display on the My Profile page stating that your approval status will be emailed to you after your request is reviewed.

<table>
<thead>
<tr>
<th>Table 1: iQIES User Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>iQIES User Role</strong></td>
</tr>
<tr>
<td>Assessment Submitter</td>
</tr>
<tr>
<td>Provider Administrator</td>
</tr>
<tr>
<td>Provider Assessment Coordinator</td>
</tr>
<tr>
<td>Provider Assessment Viewer</td>
</tr>
<tr>
<td>Provider Security Official</td>
</tr>
</tbody>
</table>
Table 2 presents a matrix that relates actions or functions to user roles and privileges for HHAs in iQIES.

<table>
<thead>
<tr>
<th>Action</th>
<th>Assessment Submitter</th>
<th>Provider Administrator</th>
<th>Provider Assessment Coordinator</th>
<th>Provider Assessment Viewer</th>
<th>Provider Security Official</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upload XML files</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>Generate and view reports</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Approve iQIES role requests</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>Add patient record</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>Modify/delete patient records</td>
<td>N/A</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>View patient records</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Create, edit, and delete assessments</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Modify and inactivate assessments</td>
<td>N/A</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>View assessments</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Submit assessments (from user tool)</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
<td>N/A</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Timing:** CMS strongly encourages HHAs to request iQIES access now, **even though assessment submission and reporting functionality will not be available until January 1, 2020.** Failure to obtain access to iQIES by December 23, 2019, will impact your ability to submit assessment data needed for claims matching purposes. Additional communications notifying HHAs when iQIES will be available for assessment submission and reporting will be sent soon.

**ADDITIONAL INFORMATION**

HHAs can find an introduction to iQIES, how to onboard, and what steps are required to initiate a HARP account (among other information) in the Internet Quality Improvement and Evaluation System (iQIES) Onboarding Guide, which is available at [https://qtso.cms.gov/system/files/qtso/iQIESOnboardingGuide-WebVersion_0.pdf](https://qtso.cms.gov/system/files/qtso/iQIESOnboardingGuide-WebVersion_0.pdf).

HHAs may find it helpful to first review the iQIES training video How to Create an Account that demonstrates this process available at [https://go.cms.gov/iQIES_Training](https://go.cms.gov/iQIES_Training).

To watch a video detailing the HARP registration process, visit [https://youtu.be/G1zj8JqxWg4](https://youtu.be/G1zj8JqxWg4).

To watch a video explaining HARP manual proofing, visit [https://www.youtube.com/watch?v=rYioFNNvTD0](https://www.youtube.com/watch?v=rYioFNNvTD0).


To review frequently asked questions related to HARP, go to [https://harp.qualitynet.org/login/help](https://harp.qualitynet.org/login/help).

For assistance with HARP onboarding, users can call the QTSO Helpdesk at (800) 339-9313 or e-mail help@qtso.com. If you have any questions related to iQIES, please send them to iQIES_Broadcast@cms.hhs.gov.

Remember only certified HHAs will be onboarded to iQIES.

**DOCUMENT HISTORY**

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<td>November 18, 2019</td>
<td>Initial article released.</td>
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</tbody>
</table>
FOR HOME HEALTH PROVIDERS

SE19027: Overview of the Patient Driven Groupings Model

The Centers for Medicare & Medicaid Services (CMS) issued the following Special Edition 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/index

MLN Matters Number: SE19027
Article Release Date: November 22, 2019
Related Change Request (CR) Number: N/A
Related CR Transmittal Number: N/A
Effective Date: January 1, 2020
Implementation Date: January 1, 2020

PROVIDER TYPE AFFECTED
This special edition MLN Matters® article is intended for physicians that order home health services.

PROVIDER ACTION NEEDED
This article provides information on the implementation of the new Home Health Prospective Payment System (HH PPS) case-mix adjustment methodology named the Patient-Driven Groupings Model (PDGM). The PDGM will be implemented for home health periods of care starting on and after January 1, 2020.

First Criteria

One of the following must be met:

1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.
2. Have a condition such that leaving his or her home is medically contraindicated.

Second Criteria

Both of the following must be met:

1. There must exist a normal inability to leave home.
2. Leaving home must require a considerable and taxing effort.

The aged person who does not often travel from home because of frailty and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet the above conditions.

The patient may be considered homebound (that is, confined to the home) if absences from the home are:

- Infrequent;
- For periods of relatively short duration;
- For the need to receive health care treatment;
- For religious services;
- To attend adult daycare programs; or
- For other unique or infrequent events (for example, funeral, graduation, trip to the barber).


Medicare covered home health services include:

- Skilled nursing (SN) care (other than solely venipuncture for the purposes of obtaining a blood sample) on part-time or intermittent basis;
- Home health aides on a part-time or intermittent basis;
- Physical therapy (PT);
- Occupational therapy (OT);
- Speech-language pathology (SLP);
Medical social services;
Routine & non-routine medical supplies (for example, catheters, catheter care supplies, ostomy bags, and ostomy care supplies);
Durable Medical Equipment (paid separately from the home health prospective payment);
Injectable osteoporosis drugs (reimbursed on a reasonable cost basis and the patient must meet certain criteria); and
Negative pressure wound therapy using disposable devices.

Changes to Home Health Payment

Since October 2000, Home Health Agencies (HHAs) have been paid under a Home Health Prospective Payment System (HH PPS) for 60-day episodes of care that include all covered home health services. The 60-day payment amount is adjusted for case-mix and area wage differences. The case-mix adjustment under this system included: a clinical dimension; a functional dimension; and a service dimension, in which payment would increase if certain thresholds of therapy visits were met.

The Bipartisan Budget Act of 2018 (BBA of 2018) includes several requirements for home health payment reform, effective January 1, 2020. These requirements include the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of payment to a 30-day unit of payment. The mandated home health payment reform resulted in the Patient-Driven Groupings Model, or PDGM. The PDGM removes the current incentive to overprovide therapy, and instead, is designed to focus more heavily on clinical characteristics and other patient information to better align Medicare payments with patients’ care needs.

The Importance of Diagnosis Reporting and Physician Documentation under the PDGM

Under the Medicare home health benefit, the patient must be under the care of a physician and must be receiving home health services under a plan of care established and periodically reviewed by a physician. Physicians play an important role in the provision of home health services and HHAs rely on documentation from the certifying physician (and/or the acute/post-acute care facility) to confirm home health eligibility, substantiate diagnoses that are populated on the home health claim and factor into the payment amount, and to help demonstrate the medical necessity of the home health services provided.

The principal diagnosis code on the home health claim will assign the home health period of care to a clinical group that explains the primary reason the patient is receiving home health services. For example, if the reported principal diagnosis is a “stage 2 pressure ulcer of the left heel”, the home health period of care would be assigned to the “wound” clinical group, meaning the primary reason for home health services is for wound care. Payment varies between each of the clinical groups to account for the differences in resource use associated with the primary reason for home health care.

There are certain diagnoses that are vague, unspecified, or not allowed to be reported as a principal diagnosis by ICD-10 coding guidelines that will not be assigned into a clinical group. If a home health claim is submitted with a principal diagnosis that would not be assigned to a clinical group under the PDGM, the claim would be returned to the HHA for more definitive diagnosis coding. The top 5 diagnoses reported on home health claims that would not be assigned to a clinical group are:

- M62.81, Muscle weakness, generalized
- R26.89 Other abnormalities of gait and mobility
- M54.5, Low back pain
- R26.81, Unsteadiness on feet
- R53.1, Weakness
For example, if a patient has been referred to home health with a principal diagnosis of “muscle weakness, generalized” (M62.81), this would not be assigned to a clinical group because this is a vague code that does not clearly support a rationale for skilled services. If the underlying etiology of the generalized muscle weakness is unknown by the time a home health referral is made, a more definitive principal diagnosis is warranted in order to justify the need for skilled services and appropriate treatment.

Further, if the original condition is resolved, but the resulting muscle weakness persists as a result of the known original diagnosis, we anticipate that a more specific code exists that accounts for why the muscle weakness is on-going, such as muscle wasting or atrophy. So, if M62.561, “muscle wasting and atrophy of the right lower leg” is reported as the principal diagnosis, the home health period of care would be assigned to the “Musculoskeletal Rehab” clinical group, meaning the primary reason for home health services is for therapy.

Additionally, if reported as a principal diagnosis, most symptom diagnoses will not be assigned to a clinical group under the PDGM. Clinically, it is important for HHAs to have a clear understanding of the patients’ diagnoses in order to safely and effectively furnish home health services. Interventions and treatment aimed at mitigating signs and symptoms of a condition may vary depending on the cause. For example, if a patient has been referred to home health with a diagnosis of “other abnormalities of gait and mobility” (R26.89), it is important for the home health clinician to know what is precipitating the abnormality. For instance, a plan of care for a gait abnormality related to a neurological diagnosis (such as Parkinson’s disease, G20) is likely to be different from a plan of care for a gait abnormality due to a fracture or injury (such as a fracture of the head and neck of femur, S72.0).

There are other, more specific ICD-10-CM diagnosis codes that could be used as the principal diagnosis instead of symptom codes to ensure that a home health period of care is accurately assigned to the appropriate clinical group reflecting the patient’s home health care needs. Symptom codes can be reported as secondary diagnoses, as appropriate, to more fully explain patient characteristics.

Reported secondary diagnoses (that is, comorbidities) also factor into the case-mix adjustment methodology under the HH PPS. For example, if there is a reported secondary diagnosis of “heart failure,” home health payment is increased for the period of care to account for the additional resource needs associated with this condition. Additionally, HHAs can report up to 24 secondary diagnoses that may be eligible for additional payment under the PDGM.

Complete, accurate, and specific diagnosis reporting by physicians, along with clinical documentation supporting all diagnoses, is important to make sure that patient characteristics are fully captured under the PDGM. However, this does not mean that the certifying physician would be required to perform additional diagnostic testing solely to certify a patient for home health services or establish a home health plan of care. Complete and comprehensive documentation of the patient’s diagnoses and other clinical conditions by the physician will help to ensure that such diagnoses support medical necessity and Medicare payment aligns with your patient’s home health resource needs.

30-Day Periods of Care under the PDGM:

While the unit of payment for home health services will be a 30-day period starting on January 1, 2020; there are no changes to timeframes for re-certifying eligibility and reviewing the home health plan of care, both of which still need to occur every 60-days (or in the case of updates to the plan of care, more often as the patient’s condition warrants). Physicians are separately paid by Medicare for certification and recertification for home health services.

Because the unit of payment is now 30-days, instead of 60-days, HHAs may have more frequent contact with the certifying physician to communicate any changes in the patient’s condition to ensure that home health payment is adjusted to account for those changes. Furthermore, the certification and the home health plan of care must be signed timely by the certifying physician because HHAs will submit a final claim with each 30-day period of care and need this important signed documentation in order to bill for home health services.
Home health services are not limited to a single 30-day period of care. An individual can continue to receive home health services for subsequent 30-day periods as long as the individual continues to meet home health eligibility criteria.

**Overview of the Patient-Driven Groupings Model**

Figure 1 below provides an overview of how 30-day periods are categorized into 432 case-mix groups for the purposes of adjusting payment under the PDGM. In particular, 30-day periods are placed into different subgroups for each of the following broad categories:

- **Admission source** (two subgroups): community or institutional admission source
- **Timing of the 30-day period** (two subgroups): early or late
- **Clinical grouping** (twelve subgroups): musculoskeletal rehabilitation; neuro/stroke rehabilitation; wounds; Medication Management, Teaching, and Assessment (MMTA) - surgical aftercare; MMTA - cardiac and circulatory; MMTA - endocrine; MMTA - gastrointestinal tract and genitourinary system; MMTA - infectious disease, neoplasms, and blood-forming diseases; MMTA - respiratory; MMTA - other; behavioral health; or complex nursing interventions
- **Functional impairment level** (three subgroups): low, medium, or high
- **Comorbidity adjustment** (three subgroups): none, low, or high based on secondary diagnoses.

In total, there are $2^2 \times 12 \times 3 \times 3 = 432$ possible case-mix adjusted payment groups.

![Figure 1: Structure of the Patient-Driven Groupings Model](image)

**Admission Source**

Under the PDGM, each 30-day period is classified into one of two admission source categories – community or institutional – depending on what healthcare setting was utilized in the 14 days prior to home health admission. Late 30-day periods are always classified as a community admission unless there was an acute inpatient hospital stay in the 14 days prior to the late home health 30-day period. A post-acute stay in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to a post-acute stay.
Timing of the 30-Day Period

Under the PDGM, the first 30-day period is classified as early. All subsequent 30-day periods (second or later) in a sequence of 30-day periods are classified as late. A sequence of 30-day periods continues until there is a gap of at least 60-days between the end of one 30-day period and the start of the next. When there is a gap of at least 60-days, the subsequent 30-day period is classified as being the first 30-day period of a new sequence (and therefore, is labeled as early).

Clinical Groups

Under the PDGM, each 30-day period is grouped into one of twelve clinical groups based on the patient’s principal diagnosis as reported on home health claims. The reported principal diagnosis provides information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit. Table 1 below describes the twelve clinical groups. These groups are designed to capture the most common types of care that Home Health Agencies (HHAs) provide.

<table>
<thead>
<tr>
<th>Table 1: PDGM Clinical Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Groups</td>
</tr>
<tr>
<td>Musculoskeletal Rehabilitation</td>
</tr>
<tr>
<td>Neuro/Stroke Rehabilitation</td>
</tr>
<tr>
<td>Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care</td>
</tr>
<tr>
<td>Behavioral Health Care</td>
</tr>
<tr>
<td>Complex Nursing Interventions</td>
</tr>
<tr>
<td>Medication Management, Teaching and Assessment (MMTA)—</td>
</tr>
<tr>
<td>• MMTA – Surgical Aftercare</td>
</tr>
<tr>
<td>• MMTA – Cardiac/Circulatory</td>
</tr>
<tr>
<td>• MMTA – Endocrine</td>
</tr>
<tr>
<td>• MMTA – GI/GU</td>
</tr>
<tr>
<td>• MMTA – ID/Neoplasms/ Blood Diseases</td>
</tr>
<tr>
<td>• MMTA – Respiratory</td>
</tr>
<tr>
<td>• MMTA – Other</td>
</tr>
</tbody>
</table>

While there are clinical groups where the primary reason for home health services is for therapy (for example, Musculoskeletal Rehabilitation) and other clinical groups where the primary reason for home health services is for nursing (for example, Complex Nursing Interventions), these groups represent the primary reason for home health services during a 30-day period of care, but not the only reason for home health care. Home health remains a multidisciplinary benefit and payment is bundled to cover all necessary services identified on the individualized home health plan of care.

Functional Impairment Level

The PDGM designates a functional impairment level for each 30-day period based on responses to the OASIS items in Table 2 below:

<table>
<thead>
<tr>
<th>Table 2: OASIS Items Used for Functional Impairment Level in the PDGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item #</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>M1033</td>
</tr>
<tr>
<td>M1800</td>
</tr>
<tr>
<td>M1810</td>
</tr>
</tbody>
</table>
Responses that indicate higher functional impairment and a higher risk of hospitalization are associated with higher resource use and are therefore assigned higher points. These points are then summed, and thresholds are applied to determine whether a 30-day period is assigned a low, medium, or high functional impairment level.

Comorbidity Adjustment

The PDGM includes a comorbidity adjustment category based on the presence of certain secondary diagnoses (for example, congestive heart failure) associated with increased resource use. Depending on a patient’s secondary diagnoses, a 30-day period may receive no comorbidity adjustment, a low comorbidity adjustment, or a high comorbidity adjustment. Home health 30-day periods of care can receive a comorbidity adjustment under the following circumstances:

- **Low comorbidity adjustment**: There is a reported secondary diagnosis that is associated with higher resource use, or;
- **High comorbidity adjustment**: There are two or more secondary diagnoses that are associated with higher resource use when both are reported together compared to if they were reported separately. That is, the two diagnoses may interact with one another, resulting in higher resource use.
- **No comorbidity adjustment**: A 30-day period would receive no comorbidity adjustment if no secondary diagnoses exist or none meet the criteria for a low or high comorbidity adjustment.

With the implementation of the PDGM in CY 2020, the physician continues to play an invaluable role in making sure that needed home health services are provided to eligible Medicare beneficiaries through accurate, specific diagnosis reporting, developing a patient-specific home health plan of care identifying all services and disciplines to provide care, and communicating with home health agencies in a timely-fashion to ensure that all Medicare requirements are met.

RESOURCES

HHA Center Web page at: [https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html](https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html)

PDGM Web page at: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html)


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<tr>
<td>November 22, 2019</td>
<td>Initial article released.</td>
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</table>

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after February 1997 are available at no cost from our website at [http://www.cgsmedicare.com](http://www.cgsmedicare.com). © 2020 Copyright, CGS Administrators, LLC.
SE19028: Payments and Payment Adjustments under the Patient-Driven Groupings Model

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/index

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Implementation Date: January 6, 2020

PROVIDER TYPE AFFECTED
This special edition MLN Matters® article is intended for Medicare-certified home health agencies, and physicians that order home health services.

PROVIDER ACTION NEEDED
This article provides information on the implementation of the new Home Health Prospective Payment System (HH PPS) case-mix adjustment methodology named the Patient-Driven Groupings Model (PDGM). The PDGM will be implemented for home health periods of care starting on and after January 1, 2020.

BACKGROUND
Since October 2000, Home Health Agencies (HHAs) have been paid under a Prospective Payment System (PPS) for a 60-day episode of care that includes all covered home health services. Covered home health services include:

- Skilled Nursing (SN) care (other than solely venipuncture for the purposes of obtaining a blood sample) on part-time or intermittent basis;
- Home health aides on a part-time or intermittent basis;
- Physical Therapy (PT);
- Occupational Therapy (OT);
- Speech-Language Pathology (SLP);
- Medical social services;
- Routine & non-routine medical supplies (for example, catheters, catheter care supplies, ostomy bags, and ostomy care supplies);
- Durable Medical Equipment (paid separately from the home health prospective payment);
- Injectable osteoporosis drug, calcitonin (reimbursed on a reasonable cost basis and the patient must meet certain criteria).

The 60-day payment amount is adjusted for case-mix and area wage differences. The case-mix adjustment under this system included a clinical dimension, a functional dimension, and a service dimension, in which payment would increase if certain thresholds of therapy visits were met.

Section 51001 of the Bipartisan Budget Act of 2018 (BBA of 2018) includes several requirements for home health payment reform, effective January 1, 2020. These requirements include the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of payment to a 30-day unit of payment. The mandated home health payment reform resulted in the Patient-Driven Groupings Model, or PDGM. The PDGM removes the current incentive to overprovide therapy, and instead, is designed to focus more heavily on clinical characteristics and other patient information to better align Medicare with patients’ care needs.
Overview of the Patient-Driven Groupings Model

The Patient-Driven Groupings Model (PDGM) uses 30-day periods as a basis for payment. Figure 1 below provides an overview of how 30-day periods are categorized into case-mix groups for the purposes of adjusting payment under the PDGM. In particular, 30-day periods are placed into different subgroups for each of the following broad categories:

- **Admission source** (two subgroups): community or institutional admission source
- **Timing of the 30-day period** (two subgroups): early or late
- **Clinical grouping** (twelve subgroups): musculoskeletal rehabilitation; neuro/stroke rehabilitation; wounds; complex nursing interventions; behavioral health; Medication Management, Teaching, and Assessment (MMTA) - surgical aftercare; MMTA - cardiac and circulatory; MMTA - endocrine; MMTA - gastrointestinal tract and genitourinary system; MMTA - infectious disease, neoplasms, and blood-forming diseases; MMTA - respiratory; MMTA - other;
- **Functional impairment level** (three subgroups): low, medium, or high
- **Comorbidity adjustment** (three subgroups): none, low, or high based on secondary diagnoses.

In total, there are $2^2*12^3*3^3 = 432$ possible case-mix adjusted payment groups. The remainder of this article provides more detail on each PDGM grouping category and additional adjustments to payment that are made within the PDGM.

**Figure 1: Structure of the Patient-Driven Groupings Model**

**Admission Source**

Under the PDGM, each 30-day period is classified into one of two admission source categories – community or institutional – depending on what healthcare setting was utilized in the 14 days prior to home health admission. Late 30-day periods are always classified as a community admission unless there was an acute inpatient hospital stay in the 14 days prior to the late home health 30-day period. A post-acute stay in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to a post-acute stay.
The Medicare claims processing system will check for the presence of an acute/post-acute Medicare claim for an institutional stay occurring within 14 days of the home health admission on an ongoing basis. However, if the HHA is aware that a beneficiary had a preceding acute/post-acute care stay, HHAs have the option to submit occurrence code 61 (hospital discharge date) or occurrence code 62 (other institutional discharge date) indicating a preceding institutional stay in order to categorize the home health admission as “institutional”.

Timing of the 30-Day Period

Under the PDGM, the first 30-day period is classified as early. All subsequent 30-day periods (second or later) in a sequence of 30-day periods are classified as late. A sequence of 30-day periods continues until there is a gap of at least 60-days between the end of one 30-day period and the start of the next. When there is a gap of at least 60-days, the subsequent 30-day period is classified as being the first 30-day period of a new sequence (and therefore, is labeled as early).

HHAs will not have to determine whether a 30-day period is early (the first 30-day period) or late (all adjacent 30-day periods beyond the first 30-day period). CMS will use Medicare claims data and not the Outcome and Assessment Information Set (OASIS) in order to determine if a 30-day period is considered early or late. Information from the Medicare claims system will be used during claims processing to automatically assign the appropriate timing category.

While the unit of payment for home health services will be a 30-day period, all other requirements (that is, certification, recertification, updates to the comprehensive assessment and plan of care) will remain on a 60-day basis. As a result, information obtained from the Outcome and Assessment Information Set (OASIS) used in the PDGM may not change over the two 30-day periods the OASIS covers. However, if a patient experiences a significant change in condition before the start of a subsequent, contiguous 30-day period; for example, due to a fall with injury; a follow-up assessment would be submitted at the start of a second 30-day period to reflect any changes in the patient’s condition, including functional abilities, and the second 30-day claim would be grouped into its appropriate case-mix group accordingly.

Clinical Groups

Under the PDGM, each 30-day period is grouped into one of twelve clinical groups based on the patient’s principal diagnosis as reported on home health claims. The reported principal diagnosis provides information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit. Table 1 below describes the twelve clinical groups. These groups are designed to capture the most common types of care that Home Health Agencies (HHAs) provide.

<table>
<thead>
<tr>
<th>Clinical Groups</th>
<th>The Primary Reason for the Home Health Encounter is to Provide:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal Rehabilitation</td>
<td>Therapy (physical, occupational or speech) for a musculoskeletal condition</td>
</tr>
<tr>
<td>Neuro/Stroke Rehabilitation</td>
<td>Therapy (physical, occupational or speech) for a neurological condition or stroke</td>
</tr>
<tr>
<td>Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care</td>
<td>Assessment, treatment &amp; evaluation of a surgical wound(s); assessment, treatment &amp; evaluation of non-surgical wounds, ulcers, burns, and other lesions</td>
</tr>
<tr>
<td>Behavioral Health Care</td>
<td>Assessment, treatment &amp; evaluation of psychiatric conditions, including substance use disorder</td>
</tr>
<tr>
<td>Complex Nursing Interventions</td>
<td>Assessment, treatment &amp; evaluation of complex medical &amp; surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies</td>
</tr>
<tr>
<td>Medication Management, Teaching and Assessment (MMTA)—</td>
<td>Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.</td>
</tr>
<tr>
<td>• MMTA – Surgical Aftercare</td>
<td></td>
</tr>
<tr>
<td>• MMTA – Cardiac/Circulatory</td>
<td></td>
</tr>
<tr>
<td>• MMTA – Endocrine</td>
<td></td>
</tr>
<tr>
<td>• MMTA – GI/GU</td>
<td></td>
</tr>
<tr>
<td>• MMTA – ID/Neoplasms/Blood Diseases</td>
<td></td>
</tr>
<tr>
<td>• MMTA – Respiratory</td>
<td></td>
</tr>
<tr>
<td>• MMTA – Other</td>
<td></td>
</tr>
</tbody>
</table>
While there are clinical groups where the primary reason for home health services is for therapy (for example, Musculoskeletal Rehabilitation) and other clinical groups where the primary reason for home health services is for nursing (for example, Complex Nursing Interventions), these groups represent the primary reason for home health services during a 30-day period of care, but not the only reason for home health care. Home health remains a multidisciplinary benefit and payment is bundled to cover all necessary services identified on the individualized home health plan of care.

Functional Impairment Level
The PDGM designates a functional impairment level for each 30-day period based on responses to the OASIS items in Table 2 below:

<table>
<thead>
<tr>
<th>Item #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1033</td>
<td>Risk for Hospitalization</td>
</tr>
<tr>
<td>M1800</td>
<td>Grooming</td>
</tr>
<tr>
<td>M1810</td>
<td>Current ability to dress upper body safely</td>
</tr>
<tr>
<td>M1820</td>
<td>Current ability to dress lower body safely</td>
</tr>
<tr>
<td>M1830</td>
<td>Bathing</td>
</tr>
<tr>
<td>M1840</td>
<td>Toilet transferring</td>
</tr>
<tr>
<td>M1850</td>
<td>Transferring</td>
</tr>
<tr>
<td>M1860</td>
<td>Ambulation and locomotion</td>
</tr>
</tbody>
</table>

Responses that indicate higher functional impairment and a higher risk of hospitalization are associated with higher resource use and are therefore assigned higher points. These points are then summed, and thresholds are applied to determine whether a 30-day period is assigned a low, medium, or high functional impairment level. Each clinical group is assigned a separate set of thresholds. On average, 30-day periods in the low level have responses for the listed OASIS items that are associated with the lowest resource use. On average, 30-day periods in the high level have responses on the above OASIS items that are associated with the highest resource use.

Comorbidity Adjustment
The PDGM includes a comorbidity adjustment category based on the presence of secondary diagnoses associated with increased resource use. Depending on a patient's secondary diagnoses, a 30-day period may receive no comorbidity adjustment, a low comorbidity adjustment, or a high comorbidity adjustment. Home health 30-day periods of care can receive a comorbidity adjustment under the following circumstances:

- **Low comorbidity adjustment**: There is a reported secondary diagnosis that is associated with higher resource use, or;
- **High comorbidity adjustment**: There are two or more secondary diagnoses that are associated with higher resource use when both are reported together compared to if they were reported separately. That is, the two diagnoses may interact with one another, resulting in higher resource use.
- **No comorbidity adjustment**: A 30-day period would receive no comorbidity adjustment if no secondary diagnoses exist or none meet the criteria for a low or high comorbidity adjustment.

A 30-day period can have a low comorbidity adjustment or a high comorbidity adjustment, but not both. A 30-day period of care can receive only one low comorbidity adjustment regardless of the number of secondary diagnoses reported on the home health claim that fell into one of the individual comorbidity subgroups or one high comorbidity adjustment regardless of the number of comorbidity group interactions, as applicable. The low comorbidity adjustment amount would be the same across the subgroups and the high comorbidity adjustment would be the same across the subgroup interactions.
**HIPPS Code**

The home health PPS Grouper will automatically draw the information from the claims and submitted OASIS assessment needed to group the 30-day period and assign the Health Insurance Prospective Payment System (HIPPS) code which corresponds to the Home Health Resource Group (HHRG) for the 30-day period of care. Each character of the HIPPS code is associated with a PDGM case-mix variable as described above. Under the PDGM, the HIPPS code is no longer required with OASIS submission. The official CMS Grouper will be updated annually along with rulemaking. Table 3 details the HIPPS code structure and the PDGM case-mix variables associated with each character position.

<table>
<thead>
<tr>
<th>Position #1</th>
<th>Position #2</th>
<th>Position #3</th>
<th>Position #4</th>
<th>Position #5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Source &amp; Timing</td>
<td>Clinical Group</td>
<td>Functional Impairment Level</td>
<td>Comorbidity</td>
<td>Placeholder</td>
</tr>
<tr>
<td>Community-Early</td>
<td>MMTA-Other</td>
<td>Low</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Institutional-Early</td>
<td>Neuro Rehab</td>
<td>Medium</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Community-Late</td>
<td>Wounds</td>
<td>High</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Institutional-Late</td>
<td>Complex Nursing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>MS Rehab</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>MMTA-Surgical Aftercare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>MMTA-Cardiac</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>MMTA-Endocrine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>MMTA-GI/GU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>MMTA-Infectious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>MMTA-Respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Determining Case-Mix Weights for the Patient-Driven Groupings Model**

The case-mix weight for each of the 432 different payment groups under the PDGM are determined by estimating a regression where the dependent variable is the resource use of a 30-day period and the independent variables are categorical indicators representing the five dimensions of the model described above (timing of a 30-day period, admission source, clinical group, functional impairment level, and comorbidities). Case-mix weights are produced by dividing the predicted resource use for each PDGM payment group by the overall average resource use of all 30-day periods. The case-mix weights are then used to adjust the 30-day payment rate. Figure 2 describes how 30-day periods are paid and when payment adjustments are made.
Additional Payment Adjustments for the Patient-Driven Groupings Model

Low Utilization Payment Adjustment (LUPA)

Payments for 30-day periods with a low number of visits are not case-mix adjusted, but instead paid on a per-visit basis using the national per-visit rates. Each of the 432 different PDGM payment groups has a threshold that determines if the 30-day period receives this Low-Utilization Payment Adjustment (LUPA). For each payment group, the 10th percentile value of visits is used to create a payment group specific LUPA threshold with a minimum threshold of at least two for each group. A 30-day period with a total number of visits below the LUPA threshold are paid per-visit rather than being paid the case-mix adjusted 30-day payment rate. A 30-day period with a total number of visits at or above the LUPA threshold is paid the case-mix adjusted 30-day payment rate rather than being paid per-visit.

Partial Payment Adjustments

Payments would be adjusted if a beneficiary transfers from one home health agency to another or is discharged and readmitted to the same agency within 30 days of the original 30-day period start date. The case-mix adjusted payment for 30-day periods of that type is pro-rated based on the length of the 30-day period ending in transfer or discharge and readmission, resulting in a partial payment adjustment.

Outlier Payments

When a 30-day period of care involves an unusually large number or a costly mix of visits, the HHA may be eligible for an additional outlier payment (See Figure 3). Once the imputed cost of a 30-day period of care exceeds a threshold amount, the HHA receives a payment equal to 80 percent of the difference between the imputed costs and the threshold amount.
RESOURCES

HHA Center Web page which has an interactive grouper tool (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/PDGM-Grouper-Tool-CY-2019.zip) for HHAs to use to see how their case-mix weights would be established with their patient populations. The HHA Center webpage also has the PDGM case mix weights, LUPA thresholds, and agency-level impacts available for download at https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html


PDGM Web page at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html

DOCUMENT HISTORY

<table>
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<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>November 22, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

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/fiss_claims_processing_issues.html](https://www.cgsmedicare.com/hhh/claims/fiss_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](https://www.cgsmedicare.com/hhh/education/materials/cses.html) has been updated with the most recent data.

- The **Home Health Patient-Driven Groupings Model (PDGM)** Web page at [https://www.cgsmedicare.com/hhh/education/materials/pdgm.html](https://www.cgsmedicare.com/hhh/education/materials/pdgm.html) has been updated to include additional CGS Resources. Here you will find PDGM instructions about submitting a Request for Anticipated Payment (RAP) and a final claim. Please share this information with your billing staff.

- The **Self-Service Options** Web page at [https://www.cgsmedicare.com/hhh/tools/index.html](https://www.cgsmedicare.com/hhh/tools/index.html) has been updated to include the NEW **Home Health Patient-Driven Groupings Model (PDGM) Final Claim Timeliness Calculator** at [https://www.cgsmedicare.com/medicare_dynamic/15/pdgm_final_claim_calc/pdgm_final_claim_calc.aspx](https://www.cgsmedicare.com/medicare_dynamic/15/pdgm_final_claim_calc/pdgm_final_claim_calc.aspx). Use this tool to prevent your Request for Anticipated Payment (RAP) from being auto-cancelled. This self-service option is also available on the **Home Health Patient-Driven Groupings Model (PDGM)** Web page at [https://www.cgsmedicare.com/hhh/education/materials/pdgm.html](https://www.cgsmedicare.com/hhh/education/materials/pdgm.html).

- The **Home Health & Hospice Customer Service Phone/Fax** Web page at [https://www.cgsmedicare.com/hhh/cs/cs_phone_fax.html](https://www.cgsmedicare.com/hhh/cs/cs_phone_fax.html) has been updated to include a link to the 2020 Customer Service Holiday / Training Schedule.

- The **HHH Recorded Webinars** Web page at [https://www.cgsmedicare.com/hhh/education/recorded_webinars.html](https://www.cgsmedicare.com/hhh/education/recorded_webinars.html) has been updated to include the recording of the November 21, 2019, Home Health Patient-Driven Groupings Model (PDGM) Webcast Part One.

- The **Hospice Occurrence Code 27 Calculator** Web page at [https://www.cgsmedicare.com/medicare_dynamic/j15/oc27calc.asp](https://www.cgsmedicare.com/medicare_dynamic/j15/oc27calc.asp) was updated to indicate that this tool does not apply in situations when the beneficiary has been discharged and readmitted to hospice.

**FOR HOME HEALTH AND HOSPICE PROVIDERS**

**Contact Information for CGS Medicare Home Health and Hospice Providers**

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center (PCC) at **1.877.299.4500** and choose Option 1. Access the Home Health and Hospice “Contact Information” Web page at [https://www.cgsmedicare.com/hhh/cs/index.html](https://www.cgsmedicare.com/hhh/cs/index.html) for information about the Interactive Voice Response (IVR) system, as well as telephone numbers, fax numbers, and mailing addresses for other CGS departments.

**BEFORE YOU CALL**

Access the new “How Do I…?” icon ([https://www.cgsmedicare.com/hhh/cs/howdoi.html](https://www.cgsmedicare.com/hhh/cs/howdoi.html)) from the Home Health & Hospice Contact Information page at [https://www.cgsmedicare.com/hhh/cs/index.html](https://www.cgsmedicare.com/hhh/cs/index.html). In addition, refer to the “Education & Resources Options” icon ([https://www.cgsmedicare.com/hhh/education/index.html](https://www.cgsmedicare.com/hhh/education/index.html)) to access resources that may be able to answer your question.

**FOR HOME HEALTH AND HOSPICE PROVIDERS**

**Medicare Credit Balance Quarterly Reminder**

This article is a reminder to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **January 30, 2020**, for the quarter ending...
December 31, 2019. A Medicare credit balance is an amount determined to be refundable to the Medicare program for an improper or excess payment made to a provider because of patient billing or claims processing errors.


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**NOTE:** Please do not submit duplicate Credit Balance Reports. To ensure CGS has received your report, consider using the website portal myCGS to submit your report. myCGS provides instant confirmation of receipt and allows you to check the status. Submitting your CBR using certified mail, or other methods that require a signature upon delivery is also an option.

The report must be postmarked by the date indicated above. If the report is received with a postmark date later than the date indicated above, we are required to withhold 100 percent of all payments being sent to your facility. This withholding will remain in effect until the reporting requirements are met. If no credit balance exists for your facility during a quarter, a signed Medicare Credit Balance Report certification is still required. Please include your Medicare provider number on the certification form.

Refer to the Medicare Credit Balance Report (CMS-838) form for complete instructions. However, for additional assistance in completing the form, refer to the “Tips on Completing a Credit Balance Report (Form CMS-838)” Web page at https://www.cgsmedicare.com/hhh/financial/838_form_tips.html on the CGS website.

To ensure timely receipt and processing, send the CMS-838/Certification within 30 days of the quarter end date using one of the options below. Do not submit duplicate Credit Balance Reports.

<table>
<thead>
<tr>
<th>myCGS, secure Web Portal (preferred method):</th>
<th>myCGS provides instant confirmation of receipt. For details, refer to:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reports may be faxed to (do not send duplicate faxes):</th>
<th>1.615.664.5987</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCBR Receipts Attn: Credit Balance Reporting</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regular and Certified Mail:</th>
<th>CGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attn: HHH Credit Balance Reporting</td>
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<tr>
<td>PO Box 20014</td>
<td></td>
</tr>
<tr>
<td>Nashville, TN 37202</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Fed Ex/ UPS/ Overnight Courier:</th>
<th>CGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>J15 Credit Balance Reporting</td>
<td></td>
</tr>
<tr>
<td>2 Vantage Way</td>
<td></td>
</tr>
<tr>
<td>Nashville, TN 37228</td>
<td></td>
</tr>
</tbody>
</table>

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Please note that if you have or will be submitting an adjustment, please send the UB-04 along with the CMS-838 form.

**If you are issuing a refund check for a credit balance:**

- Send the CMS-838 and a copy of the refund check using one of the options listed above.
- Send the refund check with a copy of the CMS-838 or documentation that indicates the check is for a credit balance, the quarter end date, and provider number associated with the check to the following address:
  
  CGS - J15 Home Health and Hospice
  PO Box 957124
  St. Louis, MO 63195-7124

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This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after February 1997 are available at no cost from our website at http://www.cgsmedicare.com. © 2020 Copyright, CGS Administrators, LLC.
If you have general questions related to the Credit Balance report, refer to the CGS Credit Balance Report (Form CMS-838) website at http://www.cgsmedicare.com/hhh/financial/CMS-588.html or call the Provider Contact Center at 1.877.299.4500 (Option 1). If you have questions about withholding, call 1.877.299.4500 (Option 4).

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.

- November 21, 2019 - https://www.cms.gov/media/453056
- December 5, 2019 - https://www.cms.gov/media/454256

FOR HOME HEALTH AND HOSPICE PROVIDERS

MM11003 (Revised): Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System

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/index

MLN Matters Number: MM11003 Revised
Related CR Release Date: April 16, 2019
Related CR Transmittal Number: R2281OTN
Related Change Request (CR) Number: 11003
Effective Date: July 1, 2019
Implementation Date: July 1, 2019

Note: We revised this article on November 1, 2019, to update and clarify information regarding the eMDR registration/enrollment to indicate the provider and the HIH roles with more detail. All other information is unchanged.

PROVIDER TYPE 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

CR 11003 introduced the enrollment process for the providers who intend to get their Additional Documentation Request (ADR) letters electronically (as eMDR) through their registered Health Information Handler (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Which_HIHs_Plan_to_Offer_Gateway_Services_to_Providers.html).

Make sure your billing staffs are aware of these changes.
BACKGROUND

In response to a number of requests from Medicare providers, the Centers for Medicare & Medicaid Services (CMS) is adding the functionality to send ADR letters electronically. CMS conducted a pilot supporting the electronic version of the ADR letter known as Electronic Medical Documentation Request (eMDR) via the esMD system. Since the eMDRs may contain Protected Health Information (PHI) data being sent to the prospective provider, CMS will require a valid consent from the authorized individual representing the provider along with the destination details including any delegation to their associated or representing organizations such as Health Information Handlers (HIHs).

The article published as a part of CR 11003 (which follows) will educate providers on the steps to be performed in order to receive the ADR letter electronically as an eMDR.

MLN ARTICLE INFORMATION ATTACHED TO CR 11003

Terminology

- NPPES: National Plan and Provider Enumeration System
- eMDR: Electronic Medical Documentation Request. (Electronic form of ADR)
- esMD: Electronic Submission of Medical Documentation
- HIH: Health Information Handler
- RC: Review Contractor
- ADR: Additional Documentation Request

Timeline

- July 2019 - Providers can register to give their consent that an HIH of their choice can receive transactions on their behalf.
- January 2020 - Providers can receive eMDR (Pre or Post Pay) through their HIH and process the data systematically.
- July 2020 - Providers can receive the list of ‘Requested Documents for an ADR’ along with eMDR through their HIH. After January release, until July release, for the Document Codes per se, providers need to refer to the PDF copy of the letter.

CMS requires its review contractors to support sending ADR letters electronically as eMDRs. The following contractors are exempted from participation in the eMDR process:

- Payment Error Rate Measurement (PERM) contractors
- The Comprehensive Error Rate Testing (CERT) contractors (can opt to participate in the eMDR process)
- Quality Improvement Organizations (QIO) (can opt to participate in the eMDR process)
- Supplemental Medical Review Contractor (SMRC)
- Unified Program Integrity Contractor (UPIC)

CMS is implementing systematic changes to esMD, for the providers to receive ADR letters (Pre/Post) electronically as eMDR. Advantages for the provider to receive eMDRs include:

- ADR letter data in an electronic format (eMDR) provides structured data that can be used for system processing
- Electronic ADR letter (as eMDR) reaches the provider faster and brings traceability to the exchange
- ADRs received electronically makes for efficient management of ADR requests and responses
**Registration**

To receive the ADRs electronically as an eMDR via the esMD system:

- Provider must ensure that they have a Business Associate Agreement (BAA) in place with an HIH of their choice.
- Provider must update the NPPES system to authorize their HIH to receive electronic transactions on their behalf (details mentioned below).
- After making the appropriate updates successfully in the NPPES, providers are expected to communicate the same to the sponsored HIH, to facilitate them to submit the eMDR registration request to esMD system, thereafter.
- HIH must complete additional processing steps after which the provider will receive eMDR

**Points to Note for Registered Providers**

1. eMDR (ADR letters sent via esMD) may have PHI data and requires:
   - Consent from authorized individual to receive electronically
   - Endpoint information where the eMDR has to be sent
   - Active agreements between Provider and HIH, covering security and privacy requirements to handle PHI data
2. eMDR enrollment must use NPPES system to gather provider consent and endpoint information (only provider's authorized individual has access to NPPES).
3. A provider (by NPI) must have an active agreement with one HIH at a time to send/receive data via esMD for all supported Lines of Businesses (LOBs).
4. A provider (by NPI) enrolling and registering for eMDR will receive ADR letters electronically via esMD from all RCs sending out ADR letters. CMS exempts PERM, CERT, UPIC, SMRC, and QIO contractors from sending eMDRs.
5. A provider (by NPI) enrolling for eMDR is applicable to all its PTANs.
6. HIH shall complete additional processing steps after which the Providers can receive eMDRs (after January 2020).
7. The eMDR registration process (new, HIH change or removal) is not effective until all process steps are completed without any discrepancies.
8. Provider is responsible to update NPPES with the latest HIH details.
9. A provider registering for the first time to receive eMDR will receive both electronically and by mail for the first three ADRs as a transition step.
10. A provider enrollment for MAC portals and DDE (Part A) are separate from eMDR enrollment and registration.

**Create New ‘Endpoint Information’ in NPPES**

Provider Profile in NPPES (to be updated by the provider’s authorized person)

**Step 1:** Navigate to the main page after logging in. ([https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov))

**Step 2:** Scroll down and click on the edit icon under the ‘Action’ column.
Step 3: Proceed to the ‘HEALTH INFORMATION EXCHANGE’ section.

Step 4: Scroll down to ‘Endpoint for Exchanging Healthcare Information (optional)’ section and fill out the details as mentioned below the screen shot.

Provider shall enter the following information in NPPES:

- Endpoint Type: ‘Connect URL’
- Endpoint: [Website URL of the HIH] *(to be provided by HIH)*
- Endpoint Description: [HIH OID] *(to be provided by HIH)*
- Endpoint Use: ‘Other’
- Other Endpoint Use: ‘CMS esMD eMDR’

Is this Endpoint affiliated to another Organization? (Here provider shall choose ‘Yes’ and enter all the details of the HIH) (If the provider themselves are HIHs then choose their own name and address)

- Affiliation: [Click on ‘Choose Affiliation’ and try to search the HIH name using ‘Organization name’ parameter]

If there are no results, Enter the HIH Organization Name (to be provided by HIH) in the ‘Affiliated Organization Legal Business Name’ and Click Save. (Shown as below)
• Endpoint location: [If the HIH address is not part of the dropdown, Click on ‘Add New Endpoint Location’ and enter the HIH address] (to be provided by HIH)

Click Save.

Step 5: After all the details are entered on this screen, please check the terms and conditions check box and click ‘Save’.

Delete an existing ‘Endpoint’ information in NPPES

Step 1: After logging in to NPPES, Navigate to the “Health Information Exchange section” you will find all existing Endpoints listed in a grid (see screen shot below)
Step 2: To delete an Endpoint, click on the “Delete” icon in the “Action” column, the system will prompt the user, click “yes” to delete the Endpoint and add another one.

**Note:** Users can only delete Endpoints. They cannot modify any endpoint.

**Use cases**

1. **A new enrollment and registration request.**
   - Provider - Provider shall enter an agreement with an HIH, for them to accept eMDR on their behalf. An authorized user of the provider shall update the NPPES system with the HIH details.
   - Provider - After updating the HIH details in the NPPES, shall inform the sponsored HIH.
   - HIH - HIHs after getting the confirmation from the providers regarding the information update in NPPES, shall send an eMDR registration request to esMD.

2. **Removal of an eMDR registered provider (does not want ADRs electronically any more).**
   - Provider - An authorized user of the provider shall remove the HIH details from the NPPES system.
   - Provider - After removal of the HIH details in NPPES, shall inform the currently sponsored HIH.
   - HIH - HIHs after getting the confirmation from the providers regarding the deletion in NPPES, shall send an eMDR remove request to esMD.

3. **Change from one HIH to the other (HIH1 to HIH2)**
   1. Provider - An authorized user of the provider shall remove HIH1 and add HIH2 details in the NPPES system.
   2. Provider - After removal of the HIH (HIH1) details in NPPES, shall inform the currently sponsored HIH, regarding the removal of the representation.
   3. Provider - After addition of the HIH (HIH2) details in NPPES, shall inform the newly sponsored HIH, regarding the addition of the representation.
   4. HIH1 - HIH1 after getting the confirmation of the deletion in NPPES, shall send an eMDR remove request to esMD.
   5. HIH2 - HIH2 after getting the confirmation of the addition in NPPES shall send an eMDR registration request to esMD.
4. **Who should Register the end point information in NPPES?**

All Provider(s) or Provider Organizations who intends to receive the Additional Documentation Request (ADRs) electronically, via esMD, as a pre-requisite need to register in NPPES.

- **Use Case A (Individual Providers)**
  
  In the current process a physical ADR letter is delivered to the provider ‘A’ with NPI 123X.
  
  If the provider is willing to receive the ADRs electronically, then the provider must register in NPPES with the details of their End-Point who will receive the electronic ADRs on their behalf.

- **Use Case B (Group Practices/Hospitals)**
  
  When a claim is submitted by a hospital or a group practice (for a provider), our assumption is, a physical ADR is being sent to the group practice or Hospital address and further gets dispersed to the intended Provider via internal communication mechanism.
  
  If the group practice/Hospital is interested to receive ADRs electronically (on behalf of their provider(s), then the group practice/Hospital specific NPI shall be registered in NPPES.

**ADDITIONAL INFORMATION**


CMS will notify providers via MLN Matters articles if there are any changes to the process of registration.

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).


**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 1, 2019</td>
<td>We revised this article to update and clarify information regarding the eMDR registration/enrollment to indicate the provider and the HIH roles with more detail.</td>
</tr>
<tr>
<td>April 17, 2019</td>
<td>We reissued this article to reflect an updated Change Request (CR) that added an MLN article attachment. The article is reissued to include the CR attachment (MLN article) in its entirety. The CR release date, transmittal number and link to the transmittal was also changed.</td>
</tr>
<tr>
<td>February 1, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
MM11216 (Revised): April 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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/index

MLN Matters Number: MM11216 Revised
Related CR Release Date: March 15, 2019
Related CR Transmittal Number: R4255CP
Related Change Request (CR) Number: 11216
Effective Date: April 1, 2019
Implementation Date: April 1, 2019

Note: We revised this article on October 29, 2019, to add a reference to a related article, SE19009 which replaces Section 6 - Chimeric Antigen Receptor (CAR) T-Cell Therapy - instructions on pages 5-7 of this article. All other information is unchanged.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for hospital outpatient facilities, physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for hospital outpatient services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11216 describes changes to, and billing instructions for, various payment policies implemented in the April 2019 OPPS update. The April 2019 Integrated Outpatient Code Editor (I/OCE) will reflect the HCPCS, Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR11216. Make sure your billing staffs are aware of these changes.

BACKGROUND

The April 2019 revisions to I/OCE data files, instructions, and specifications are provided in CR 11192. You will find an article related to that CR at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11192.pdf. The following summarizes the OPPS changes for April 2019.

PROPRIETARY LABORATORY ANALYSES (PLA) CURRENT PROCEDURAL TERMINOLOGY (CPT) CODING CHANGES EFFECTIVE JANUARY 1, 2019

The American Medical Association (AMA) CPT Editorial Panel established four new PLA CPT codes, specifically, CPT codes 0080U through 0083U effective January 1, 2019. Because the codes were released on November 30, 2018, they were too late to include in the January 2019 OPPS update and are instead included in the April 2019 update with an effective date of January 1, 2019.

Table 1 lists the long descriptors and status indicators for CPT codes 0080U through 0083U. For more information on OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the Calendar Year (CY) 2019 OPPS/ASC (Ambulatory Surgery Center) final rule for the latest definitions. CPT codes 0080U through 0083U have been added to the April 2019 I/OCE with an effective date of January 1, 2019. These codes, along with their short descriptors and status indicators, will also be in the April 2019 OPPS Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.
### Table 1: Proprietary Laboratory Analyses (PLA) CPT Coding Changes - Effective January 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>0080U</td>
<td>Oncology (lung), mass spectrometric analysis of galectin-3-binding protein and scavenger receptor cysteine-rich type 1 protein M130, with five clinical risk factors (age, smoking status, nodule diameter, nodule-spiculation status and nodule location), utilizing plasma, algorithm reported as a categorical probability of malignancy</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0081U</td>
<td>Oncology (uveal melanoma), mRNA, gene-expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping genes), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0082U</td>
<td>Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of each drug, drug metabolite or substance with description and severity of significant interactions per date of service</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0083U</td>
<td>Oncology, response to chemotherapy drugs using motility contrast tomography, fresh or frozen tissue, reported as likelihood of sensitivity or resistance to drugs or drug combinations</td>
<td>Q4</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### 1. New Advanced Diagnostic Laboratory Test (ADLT) Under the Clinical Lab Fee Schedule (CLFS)

On December 21, 2018, effective January 1, 2019, the laboratory test described by CPT code 81538 (Oncology (lung), mass spectrometric 8-protein signature, including amyloid a, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival), was approved as an ADLT. Based on the ADLT designation, the Centers for Medicare & Medicaid Services (CMS) revised the OPPS status indicator for CPT code 81538 from “Q4” to “A” effective January 1, 2019. However, because the code’s ADLT designation was made December 2018, it was too late to include this change the January 2019 OPPS update, therefore, CMS is including this change in the April 2019 update with an effective date of January 1, 2019. The latest list of ADLT codes is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/List-of-Approved-ADLTs.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/List-of-Approved-ADLTs.pdf).

For more information on the OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2019 OPPS/ASC final rule for the latest definitions. CMS has added CPT code 81538 to the April 2019 I/OCE with an effective date of January 1, 2019. CPT code 81538, along with its short descriptor and status indicator, is also listed in the April 2019 OPPS Addendum B.

#### 2. The Comprehensive APC (C-APC) Exclusion List

CR 11216 updates the Comprehensive APC (C-APC) exclusion list in section 10.2.3, chapter 4 of the Medicare Claims Processing Manual to match the list provided in Addendum J of the CY 2019 OPPS/ASC Final Rule. The additions to the list included brachytherapy sources, self-administered drugs, services assigned to status indicators F and L, certain part B inpatient services, and therapy services.

#### 3. Drugs, Biologicals, and Radiopharmaceuticals

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

For CY 2019, seven 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 below in Table 2.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9040</td>
<td>Injection, fremanezumab-vfrm, 1mg</td>
<td>G</td>
<td>9197</td>
</tr>
<tr>
<td>C9041</td>
<td>Injection, coagulation factor Xa (recombinant), inactivated (andexxa), 10mg</td>
<td>G</td>
<td>9198</td>
</tr>
<tr>
<td>C9141</td>
<td>Injection, factor viii, (antihemophilic factor, recombinant), pegylated-acl (jivi) 1 i.u.</td>
<td>G</td>
<td>9299</td>
</tr>
</tbody>
</table>
### b. Separately Payable Drugs and Biologicals that Will Receive Pass-Through Status (Status Indicator “G”) Effective April 1, 2019

Some separately payable drugs and biologicals will change from status indicator “K” to status indicator “G” effective April 1, 2019 as these drugs and biologicals have been given pass-through status. These drugs and biologicals are reported below in Table 3.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Old SI</th>
<th>New SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9043</td>
<td>Injection, levoeleucovorin, 1 mg</td>
<td>G</td>
<td>9303</td>
<td></td>
</tr>
<tr>
<td>C9044</td>
<td>Injection, cemiplimab-rwlc, 1 mg</td>
<td>G</td>
<td>9304</td>
<td></td>
</tr>
<tr>
<td>C9045</td>
<td>Injection, moxetumomab pasudotox-tdfk, 0.01 mg</td>
<td>G</td>
<td>9305</td>
<td></td>
</tr>
<tr>
<td>C9046</td>
<td>Cocaine hydrochloride nasal solution for topical administration, 1 mg</td>
<td>G</td>
<td>9307</td>
<td></td>
</tr>
</tbody>
</table>

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

For CY 2019, payment for nonpass-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. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective April 1, 2019, payment rates for some drugs and biologicals have changed from the values published in the January 2019 update of the OPPS Addendum A and Addendum B 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). CMS is not publishing the updated payment rates in this CR implementing the April 2019 update of the OPPS. However, the updated payment rates effective April 1, 2019 are in the April 2019 update of the OPPS Addendum A and Addendum B 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).

### d. 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 CMS website on the first date of the quarter at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/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.

### 4. Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after February 1997 are available at no cost from our website at [http://www.cgsmedicare.com](http://www.cgsmedicare.com). © 2020 Copyright, CGS Administrators, LLC.
Four skin substitute products, HCPCS codes Q4183, Q4184, Q4194, and Q4203 have been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The products are listed in Table 4.

### Table 4: Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group - Effective April 1, 2019

<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>Q4183</td>
<td>Surgigraft, 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4184</td>
<td>Cellesta, 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4194</td>
<td>Novachor 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4203</td>
<td>Derma-gide, 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

5. **Chimeric Antigen Receptor (CAR) T-Cell Therapy**


(CAR) T-cell therapy is a cell-based gene therapy in which T-cells are collected and genetically engineered to express a chimeric antigen receptor that will bind to a certain protein on a patient’s cancerous cells. The CAR T-cells are then administered to the patient to attack certain cancerous cells and the individual is observed for potential serious side effects that would require medical intervention.

As stated in the CY 2019 OPPS/ASC final rule, CMS is continuing OPPS pass-through payment status for CAR T HCPCS codes Q2041 (Yescarta) and Q2042 (Kymriah) (see long descriptors in Table 5). The OPPS pass-through payment rate is determined following the standard ASP methodology, updated on a quarterly basis if applicable information indicates that adjustments to the payment rates are necessary.

As shown in Table 5, the HCPCS Q-code for each currently approved CAR T-cell therapy includes leukapheresis and dose preparation procedures. The procedures described by CPT codes 0537T, 0538T, and 0539T describe various steps required to collect and prepare the genetically modified T-cells, and Medicare does not generally pay separately for each step used to manufacture a drug or biological. Therefore, in the CY 2019 OPPS/ASC final rule, CPT codes 0537T, 0538T, and 0539T were assigned to status indicator “B” (Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x). However, as noted in the OPPS final rule, it will be possible for Medicare to track utilization and cost data from hospitals reporting these services, even for HCPCS codes reported for services in which no separate payment is made under the OPPS. The CAR T-cell related revenue codes and value code established by the National Uniform Billing Committee (NUBC) will be reportable on Hospital Outpatient Department (HOPD) claims, and will be available for tracking utilization and cost data, effective for claims received on or after April 1, 2019.

### Table 5: CAR T-cell Therapy Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptors</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2041</td>
<td>Axicabtagene ciloleucel, up to 200 million autologous antiCD 19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose</td>
<td>G</td>
<td>9035</td>
</tr>
<tr>
<td>Q2042</td>
<td>Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose</td>
<td>G</td>
<td>9194</td>
</tr>
<tr>
<td>0537T</td>
<td>Chimeric antigen receptor t-cell (car-t) therapy; harvesting of blood-derived t lymphocytes for development of genetically modified autologous car-t cells, per day</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>0538T</td>
<td>Chimeric antigen receptor t-cell (car-t) therapy; preparation of blood-derived t lymphocytes for transportation (eg, cryopreservation, storage)</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>0539T</td>
<td>Chimeric antigen receptor t-cell (car-t) therapy; receipt and preparation of car-t cells for administration</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>0540T</td>
<td>Chimeric antigen receptor t-cell (car-t) therapy; car-t cell administration, autologous</td>
<td>S</td>
<td>5694</td>
</tr>
</tbody>
</table>
Effective April 1, 2019, hospitals may report CPT codes 0537T, 0538T, and 0539T, as non-covered items/services to allow for Medicare to track these services when furnished in the outpatient setting. Also, hospitals may report the CAR T-cell related revenue codes 087X (Cell/Gene Therapy) and 089X (Pharmacy) as well as new value code 86 (Invoice Cost) established by the NUBC on HOPD claims.

CMS reminds hospitals that the administration of CAR T-cells in the hospital outpatient setting is paid separately under CPT code 0540T, which is assigned status indicator “S”.

Below is further clarification on billing of CAR-T related items and services in various clinical scenarios.

- **Scenario 1: CAR-T Dosing and Preparation Services and Viable T-cells Administered in Hospital Outpatient Setting:** In those instances when the CAR-T drug is administered in the hospital outpatient setting, report CPT code 0540T for the administration and HCPCS Q-code Q2041 or Q2042 for the drug/biological. As stated in the CY 2019 OPPS/ASC final rule, the procedures described by CPT codes 0537T (collection/handling), 0538T (preparation for transport), and 0539T (receipt and preparation) represent the various steps required to collect the cells and prepare the genetically modified T-cells are not separately payable. However, these services may be reported as non-covered charges on the outpatient claim.

- **Scenario 2: CAR-T Dosing and Preparation Services Administered in Hospital Outpatient Setting, but Viable T-cells not Administered:** In those instances when the CAR-T drug is not ultimately administered to the patient, but the CAR-T preparation services are initiated or performed in the HOPD facility, hospital outpatient departments may report CPT codes 0537T, 0538T, and 0539T (as appropriate) and the charges associated with each code under the appropriate revenue code on the HOPD claim as non-covered charges.

- **Scenario 3: CAR-T Dosing and Preparation Services Administered in Hospital Outpatient Setting, but Viable T-cells Administered in the Hospital Inpatient Setting:** When CAR T-cell preparation services are initiated and furnished in the hospital outpatient setting, but the CAR T-cells are administered in the inpatient setting following inpatient admission to the hospital more than 3 days after the related outpatient services are furnished, the hospital may not report the drug Q-code (which only applies when the T-cells are administered in the HOPD setting). However, the charges associated with the CAR T-cell dosing and preparation services as described by CPT codes 0537T, 0538T, and 0539T may be reported on the inpatient claim (bill type 11x) using revenue code 0891 – Special Processed Drugs – FDA (Food and Drug Administration) Approved Cell Therapy - Charges for Modified cell therapy.

Providers who have additional questions not covered by CR 11216 should consult their MAC for additional guidance on billing for these services.

6. **Modifier “ER”**

Effective January 1, 2019, hospitals were required to report new HCPCS modifier “ER” (Items and services furnished by a provider-based off-campus emergency department) on every claim line that contains a CPT/HCPCS code for an outpatient hospital service furnished in an off-campus provider-based emergency department. Modifier ER would be reported on the UB–04 form (CMS Form 1450) for hospital outpatient services. Critical Access Hospitals (CAHs) would not be required to report this modifier.

Modifier ER is required to be reported in provider-based off-campus emergency departments that meet the definition of a “dedicated emergency department” as defined in 42 Code of Federal Regulations (CFR) 489.24 under the Emergency Medical Treatment and Labor Act (EMTALA) regulations. Per 42 CFR 489.24, a “dedicated emergency department” means any department or facility of the hospital, regardless of
whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

1. It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

This policy change is in the revised section 20.6.18 of Chapter 4 of the Medicare Claims Processing Manual, which is attached to CR 11216.

7. 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. 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 it is excluded from payment.

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 of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>October 29, 2019</td>
<td>We revised this article to add a reference to a related article, SE19009 which replaces CAR-T instructions in CR 11216 (page 7 in this article).</td>
</tr>
<tr>
<td>March 19, 2019</td>
<td>Initial article released.</td>
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</tbody>
</table>
FOR HOME HEALTH AND HOSPICE PROVIDERS

MM11422 (Revised): Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update

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/index

MLN Matters Number: MM11422 Revised
Related CR Transmittal Number: R4443CP
Effective Date: October 1, 2019
Related CR Release Date: November 4, 2019
Related Change Request (CR) Number: 11422
Implementation Date: October 7, 2019

Note: We revised this article on November 5, 2019, to reflect the revised CR11422 issued on November 4, 2019. The revised CR added HCPCS code J0642, and we added that code in the article. 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, providers, and suppliers billing Medicare Administrative Contractors (MACs) for drug and biological services.

PROVIDER ACTION NEEDED
CR 11422 updates the HCPCS code set for codes related to drugs and biologicals. Make sure your billing staffs are aware of these updates.

BACKGROUND
The HCPCS code set is updated quarterly. CR 11422 informs MACs and providers of the latest updates to specific drug/biological HCPCS codes. The October 2019 quarterly HCPCS file includes forty-five (45) new HCPCS codes. Effective for claims with dates of service on or after October 1, 2019, you may use, as appropriate, the following HCPCS codes on claims for Medicare:

1. J0121
   a. Short Descriptor: Inj., omadacycline, 1 mg
   b. Long Descriptor: Injection, omadacycline, 1 mg
   c. Type of Service (TOS): 1,P
2. J0122
   a. Short Descriptor: Inj., eravacycline, 1 mg
   b. Long Descriptor: Injection, eravacycline, 1 mg
   c. TOS: 1,P
3. J0222
   a. Short Descriptor: Inj., patisiran, 0.1 mg
   b. Long Descriptor: Injection, Patisiran, 0.1 mg
   c. TOS: 1
4. J0291
   a. Short Descriptor: Inj., plazomicin, 5 mg
   b. Long Descriptor: Injection, Plazomicin, 5 mg
   c. TOS: 1
5. J0593
   a. Short Descriptor: Inj., lanadelumab-flyo, 1 mg

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after February 1997 are available at no cost from our website at http://www.cgsmedicare.com © 2020 Copyright, CGS Administrators, LLC.
b. Long Descriptor: Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)
c. TOS: 1

6. J1096
a. Short Descriptor: Dexametha opth insert 0.1 mg
b. Long Descriptor: Dexamethasone, lacrimal ophthalmic insert, 0.1 mg
c. TOS: 1

7. J1097
a. Short Descriptor: Phenylep ketorol ac opth soln
b. Long Descriptor: Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml
c. TOS: 1

8. J1303
a. Short Descriptor: Inj., ravulizumab-cwvz 10 mg
b. Long Descriptor: Injection, ravulizumab-cwvz, 10 mg
c. TOS: 1,P

9. J1943
a. Short Descriptor: Inj., aristada initio, 1 mg
b. Long Descriptor: Injection, aripiprazole lauroxil, (aristada initio), 1 mg
c. TOS: 1

10. J1944
a. Short Descriptor: Inj., aripirazole lauroxil 1 mg
b. Long Descriptor: Injection, aripiprazole lauroxil, (aristada), 1 mg
c. TOS: 1

11. J2798
a. Short Descriptor: Inj., perseris, 0.5 mg
b. Long Descriptor: Injection, risperidone, (perseris), 0.5 mg
c. TOS: 1,P

12. J3031
a. Short Descriptor: Inj., fremanezumab-vfrm 1 mg
b. Long Descriptor: Injection, fremanezumab-vfrm, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)
c. TOS: 1, P

13. J3111
a. Short Descriptor: Inj. romosozumab-aqqg 1 mg
b. Long descriptor: Injection, romosozumab-aqqg, 1 mg
c. TOS: 1

14. J7314
a. Short Descriptor: Inj., yutiq, 0.01 mg
b. Long Descriptor: Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg
c. TOS: 1

15. J7331
a. Short Descriptor: Synojoynt, inj., 1 mg
b. Long Descriptor: Hyaluronan or derivative, synojoynt, for intra-articular injection, 1 mg
c. TOS: 1
16. J7332
   a. Short Descriptor: Inj., triluron, 1 mg
   b. Long Descriptor: Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg
   c. TOS: 1

17. J7401
   a. Short Descriptor: Mometasone furoate sinus imp
   b. Long Descriptor: Mometasone furoate sinus implant, 10 micrograms
   c. TOS: 1

18. J9118
   a. Short Descriptor: Inj. Calaspargase pegol-mknl
   b. Long Descriptor: Injection, calaspargase pegol-mknl, 10 units
   c. TOS: 1,P

19. J9119
   a. Short Descriptor: Inj., cemiplimab-rwlc, 1 mg
   b. Long Descriptor: Injection, cemiplimab-rwlc, 1 mg
   c. TOS: 1

20. J9204
   a. Short Descriptor: Inj, mogamulizumab-kpkc, 1 mg
   b. Long Descriptor: Injection, mogamulizumab-kpkc, 1 mg
   c. TOS: 1,P

21. J9210
   a. Short Descriptor: Inj., emapalumab-lzsg, 1 mg
   b. Long Descriptor: Injection, emapalumab-lzsg, 1 mg
   c. TOS: 1

22. J9269
   a. Short Descriptor: Inj. tagraxofusp-erzs 10 mcg
   b. Long Descriptor: Injection, tagraxofusp-erzs, 10 micrograms
   c. TOS: 1

23. J9313
   a. Short Descriptor: Inj., lumoxiti, 0.01 mg
   b. Long Descriptor: Injection, moxetumomab pasudotox-tdfk, 0.01 mg
   c. TOS: 1,P

24. Q4205
   a. Short Descriptor: Membrane graft or wrap sq cm
   b. Long Descriptor: Membrane graft or membrane wrap, per square centimeter
   c. TOS: 1

25. Q4206
   a. Short Descriptor: Fluid flow or fluid gf 1 cc
   b. Long Descriptor: Fluid flow or fluid GF, 1 cc
   c. TOS: 1

26. Q4208
   a. Short Descriptor: Novafix per sq cm
   b. Long Descriptor: Novafix, per square centimeter
   c. TOS: 1

27. Q4209
   a. Short Descriptor: Surgraft per sq cm
   b. Long Descriptor: Surgraft, per square centimeter
   c. TOS: 1
28. Q4210
   a. Short Descriptor: Axolotl graf dualgraf sq cm
   b. Long Descriptor: Axolotl graft or axolotl dualgraft, per square centimeter
   c. TOS: 1

29. Q4211
   a. Short Descriptor: Amnion bio or axobio sq cm
   b. Long Descriptor: Amnion bio or Axobiomembrane, per square centimeter
   c. TOS: 1

30. Q4212
   a. Short Descriptor: Allogen, per cc
   b. Long Descriptor: Allogen, per cc
   c. TOS: 1

31. Q4213
   a. Short Descriptor: Ascent, 0.5 mg
   b. Long Descriptor: Ascent, 0.5 mg
   c. TOS: 1

32. Q4214
   a. Short Descriptor: Cellesta cord per sq cm
   b. Long Descriptor: Cellesta cord, per square centimeter
   c. TOS: 1

33. Q4215
   a. Short Descriptor: Axolotl ambient, cryo 0.1 mg
   b. Long Descriptor: Axolotl ambient or axolotl cryo, 0.1 mg
   c. TOS: 1

34. Q4216
   a. Short Descriptor: Artacent cord per sq cm
   b. Long Descriptor: Artacent cord, per square centimeter
   c. TOS: 1

35. Q4217
   a. Short Descriptor: Woundfix biowound plus xplus
   b. Long Descriptor: Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or BioWound Xplus, per square centimeter
   c. TOS: 1

36. Q4218
   a. Short Descriptor: Surgicord per sq cm
   b. Long Descriptor: Surgicord, per square centimeter
   c. TOS: 1

37. Q4219
   a. Short Descriptor: Surgigraft dual per sq cm
   b. Long Descriptor: Surgigraft-dual, per square centimeter
   c. TOS: 1

38. Q4220
   a. Short Descriptor: Bellacell HD, Surederm sq cm
   b. Long Descriptor: BellaCell HD or Surederm, per square centimeter
   c. TOS: 1

39. Q4221
   a. Short Descriptor: Amniowrap2 per sq cm
   b. Long Descriptor: Amniowrap2, per square centimeter
   c. TOS: 1
40. Q4222
   a. Short Descriptor: Progenamatrix, per sq cm
   b. Long Descriptor: Progenamatrix, per square centimeter
   c. TOS: 1

41. Q4226
   a. Short Descriptor: Myown harv prep proc sq cm
   b. Long Descriptor: MyOwn skin, includes harvesting and preparation procedures, per square centimeter
   c. TOS: 1

42. Q5116
   a. Short Descriptor: Inj., trazimera, 10 mg
   b. Long Descriptor: Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg
   c. TOS: 1,P

43. Q5117
   a. Short Descriptor: Inj., kanjinti, 10 mg
   b. Long Descriptor: Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg
   c. TOS: 1,P

44. Q5118
   a. Short Descriptor: Inj., zirabev, 10 mg
   b. Long Descriptor: Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg
   c. TOS: 1,P

45. J0642
   a. Short Descriptor: Injection, khapzory, 0.5 mg
   b. Long Descriptor: Injection, levoleucovorin (khapzory), 0.5 mg
   c. TOS: 1,P

HCPCS codes J1942 (Aripiprazole lauroxil 1mg/Injection, aripiprazole lauroxil, 1 mg) and S1090 (Mometasone sinus implant/Mometasone furoate sinus implant, 370 micrograms) are being discontinued effective October 1, 2019; and may not be used in submitting claims to Medicare with dates of service on or after that date.

Effective for claims with dates of service on or after October 1, 2019, the long and short descriptors for the following HCPCS codes will be modified. The TOS and all other indicators will remain the same.

1. J0641
   a. New Short Descriptor: Inj., levoleucovorin, 0.5 mg
   b. New Long Descriptor: Injection, levoleucovorin, 0.5 mg

2. J2794
   a. New Short Descriptor: Inj., risperdal consta, 0.5 mg
   b. New Long Descriptor: Injection, risperidone (risperdal consta), 0.5 mg

3. J7311
   a. a. New Short Descriptor: Inj., retisert, 0.01 mg
   b. b. New Long Descriptor: Injection, fluocinolone acetonide, intravitreal implant (retisert), 0.01 mg

4. J7313
   a. New Short Descriptor: Inj., iluvien, 0.01 mg
   b. New Long Descriptor: Injection, fluocinolone acetonide, intravitreal implant (Iluvien), 0.01 mg

5. Q4122
   a. New Short Descriptor: Dermacell, awm, porous sq cm
6. Q4165
   a. New Short Descriptor: Keramatrix, Kerasorb sq cm
   b. New Long Descriptor: Keramatrix or kerasorb, per square centimeter

7. Q4184
   a. New Short Descriptor: Cellesta or duo per sq cm
   b. New Long Descriptor: Cellesta or cellesta duo, per square centimeter

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

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<tr>
<td>November 5, 2019</td>
<td>Note: We revised this article to reflect the revised CR11422 issued on November 4, 2019. The revised CR added HCPCS code J0642 and we added that code in the article. 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>September 18, 2019</td>
<td>We revised the article to reflect the revised CR11422 issued on September 17. The revised CR had no impact on the content of the article. In the article, we revised the CR release date, transmittal number, and the Web address of the CR. All other information remains the same.</td>
</tr>
<tr>
<td>August 16, 2019</td>
<td>Initial article released.</td>
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FOR HOME HEALTH AND HOSPICE PROVIDERS

MM11451 (Revised): October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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/index

MLN Matters Number: MM11451 Revised
Related CR Release Date: October 4, 2019
Related CR Transmittal Number: R4411CP
Related Change Request (CR) Number: 11451
Effective Date: October 1, 2019
Implementation Date: October 7, 2019

Note: We revised this article on November 5, 2019, to clarify that the providers affected are institutional providers. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters article is for institutional providers billing Medicare Administrative Contractors (MACs) for hospital outpatient services provided to Medicare beneficiaries.
PROVIDER ACTION NEEDED

CR 11451 describes changes to and billing instructions for various payment policies that Medicare is implementing in the October 2019 Outpatient Prospective Payment System (OPPS) update. Make sure your billing staffs are aware of these changes.

BACKGROUND

The October 2019 Integrated Outpatient Code Editor (I/OCE) will reflect the HCPCS, Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 11451.

The October 2019 revisions to I/OCE data files, instructions, and specifications are provided in the October 2019 I/OCE CR, which will be available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4383CP.pdf.

1. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective Oct 1, 2019

The American Medical Association (AMA) CPT Editorial Panel deleted one PLA code (0104U) and established 34 new PLA codes (CPT codes 0105U-0138U), effective October 1, 2019. Table 1 lists the long descriptors and status indicators for the codes.


Table 1: Newly Established PLA Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<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>D</td>
<td>N/A</td>
</tr>
<tr>
<td>0105U</td>
<td>Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APO1 genotype if available, and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD)</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0106U</td>
<td>Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope carbon-13 (13C) spirulina substrate, analysis of each specimen by gas isotope ratio mass spectrometry, reported as rate of 13CO2 excretion</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0107U</td>
<td>Clostridium difficile toxin(s) antigen detection by immunossay technique, stool, qualitative, multiple-step method</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0108U</td>
<td>Gastroenterology (Barrett’s esophagus), whole slide–digital imaging, including morphometric analysis, computer-assisted quantitative immunolabeling of 9 protein biomarkers (p16, AMACR, p53, CD68, COX-2, CD45RO, HIF1a, HER-2, K20) and morphology, formalin-fixed paraffin-embedded tissue, algorithm reported as risk of progression to high-grade dysplasia or cancer</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0109U</td>
<td>Infectious disease (Aspergillus species), real-time PCR for detection of DNA from 4 species (A. fumigatus, A. terreus, A. niger, and A. flavus), blood, lavage fluid, or tissue, qualitative reporting of presence or absence of each species</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0110U</td>
<td>Prescription drug monitoring, one or more oral oncology drug(s) and substances, definitive tandem mass spectrometry with chromatography, serum or plasma from capillary blood or venous blood, quantitative report with steady-state range for the prescribed drug(s) when detected</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0111U</td>
<td>Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis, utilizing formalin-fixed paraffin-embedded tissue</td>
<td>A</td>
<td>N/A</td>
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### Table 1: Newly Established PLA Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0112U</td>
<td>Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0113U</td>
<td>Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0114U</td>
<td>Gastroenterology (Barrett’s esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett’s esophagus</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0115U</td>
<td>Respiratory infectious agent detection by nucleic acid (DNA and RNA), 18 viral types and subtypes and 2 bacterial targets, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0116U</td>
<td>Prescription drug monitoring, enzyme immunoassay of 35 or more drugs confirmed with LC-MS/MS, oral fluid, algorithm results reported as a patient-compliance measurement with risk of drug to drug interactions for prescribed medications</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0117U</td>
<td>Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3-hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid), LC-MS/MS, urine, algorithm reported as a pain-index score with likelihood of atypical biochemical function associated with pain</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0118U</td>
<td>Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA in the total cell-free DNA</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0119U</td>
<td>Cardiology, ceramides by liquid chromatography–tandem mass spectrometry, plasma, quantitative report with risk score for major cardiovascular events</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0120U</td>
<td>Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBC) and diffuse large B-cell lymphoma (DLBCL) with cell of origin subtyping in the latter</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0121U</td>
<td>Sickle cell disease, microfluidic flow adhesion (VCAM-1), whole blood</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0122U</td>
<td>Sickle cell disease, microfluidic flow adhesion (P-Selectin), whole blood</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0123U</td>
<td>Mechanical fragility, RBC, shear stress and spectral analysis profiling</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0124U</td>
<td>Fetal congenital abnormalities, biochemical assays of 3 analytes (free beta-hCG, PAPP-A, AFP), time-resolved fluorescence immunoassay, maternal dried-blood spot, algorithm reported as risk scores for fetal trisomies 13/18 and 21</td>
<td>E1</td>
<td>N/A</td>
</tr>
<tr>
<td>0125U</td>
<td>Fetal congenital abnormalities and perinatal complications, biochemical assays of 5 analytes (free beta-hCG, PAPP-A, AFP, placental growth factor, and inhibin-A), time-resolved fluorescence immunoassay, maternal serum, algorithm reported as risk scores for fetal trisomies 13/18, 21, and preeclampsia</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0126U</td>
<td>Fetal congenital abnormalities and perinatal complications, biochemical assays of 5 analytes (free beta-hCG, PAPP-A, AFP, placental growth factor, and inhibin-A), time-resolved fluorescence immunoassay, includes qualitative assessment of Y chromosome in cell-free fetal DNA, maternal serum and plasma, predictive algorithm reported as a risk scores for fetal trisomies 13/18, 21, and preeclampsia</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0127U</td>
<td>Obstetrics (preeclampsia), biochemical assays of 3 analytes (PAPP-A, AFP, and placental growth factor), time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0128U</td>
<td>Obstetrics (preeclampsia), biochemical assays of 3 analytes (PAPP-A, AFP, and placental growth factor), time-resolved fluorescence immunoassay, includes qualitative assessment of Y chromosome in cell-free fetal DNA, maternal serum and plasma, predictive algorithm reported as a risk score for preeclampsia</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0129U</td>
<td>Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, and TP53)</td>
<td>A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
2. New CPT Category II Codes Effective October 1, 2019

For the October 2019 update, the Centers for Medicare & Medicaid Services (CMS) is implementing five new CPT Category II codes that the AMA released on July 8, 2019, for implementation on October 1, 2019. New CPT codes 2023F, 2025F, 2033F, 3051F, and 3052F are in the October 2019 I/OCE with an effective date of October 1, 2019.

Also, the AMA is revising the code descriptors for CPT codes 2022F, 2024F, 2026F, and deleting 3045F on September 30, 2019. The status indicators and APC assignments for the codes are shown in Table 2 These codes, along with their short descriptors, status indicators, and payment rates are listed in the October 2019 OPPS Addendum B that is posted at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. For information on the OPPS status indicator “M”, refer to OPPS Addendum D1 of the CY 2019 OPPS/ASC final rule for the latest definition.

### Table 2: New, Revised, and Deleted CPT Category II Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Status</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022F</td>
<td>REVISE</td>
<td>Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)²</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>2023F</td>
<td>NEW</td>
<td>Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)²</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>2024F</td>
<td>REVISE</td>
<td>7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)²</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>2025F</td>
<td>NEW</td>
<td>7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)²</td>
<td>M</td>
<td>N/A</td>
</tr>
</tbody>
</table>
3. **Advanced Diagnostic Laboratory Tests (ADLT) Under the Clinical Lab Fee Schedule (CLFS)**

On May 17, 2019, CMS announced the approval of three laboratory tests as ADLTs under paragraph (1) of the definition of an ADLT in 42 CFR Section 414.502. CMS notes that under the OPPS, tests that receive ADLT status under Section 1834A(d)(5)(A) of the Social Security Act (the Act) are assigned to status indicator “A.” These laboratory tests are listed in Table 3.

Based on the ADLT designation, CMS revised the OPPS status indicator for HCPCS codes 0080U and 81599 to “A” (Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS) effective July 1, 2019. However, because the ADLT designation was made in May 2019, it was too late to include this change in the July 2019 I/OCE Release and the July 2019 OPPS update; therefore, we are including this change in the October 2019 I/OCE Release with an effective date of July 1, 2019.

Note that the DecisionDx-UM test, as described by HCPCS code 0081U, was also approved for ADLT status on May 17, 2019, however it was already assigned OPPS SI “A” based on being a molecular pathology test.

The latest list of ADLTs under the CLFS is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/List-of-Approved-ADLTs.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/List-of-Approved-ADLTs.pdf). For more information on the OPPS status indicator “A”, refer to OPPS Addendum D1 of the CY 2019 OPPS/ASC final rule for the latest definitions.

### Table 3: ADLT Codes and Long Descriptors

<table>
<thead>
<tr>
<th>Lab Name</th>
<th>Test Name</th>
<th>CPT Code</th>
<th>CPT Code Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biodesix</td>
<td>BDX-XL2</td>
<td>0080U</td>
<td>Oncology (lung), mass spectrometric analysis of galectin-3-binding protein and scavenger receptor cysteine-rich type 1 protein M130, with five clinical risk factors (age, smoking status, nodule diameter, nodule-spiculation status and nodule location), utilizing plasma, algorithm reported as a categorical probability of malignancy</td>
</tr>
<tr>
<td>Castle BioSciences, Inc.</td>
<td>DecisionDX-Melanoma</td>
<td>81599*</td>
<td>Unlisted multianalyte assay with algorithmic analysis</td>
</tr>
<tr>
<td>Castle BioSciences Inc.</td>
<td>DecisionDx-UM</td>
<td>0081U</td>
<td>Oncology (uveal melanoma), mRNA, gene-expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping genes), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis</td>
</tr>
</tbody>
</table>

* DecisionDx-Melanoma is currently described by HCPCS codes 81599 and identifier ZB1D4.

4. **Drugs, Biologicals, and Radiopharmaceuticals**

   a. **HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-through Status**
For October 2019, two HCPCS codes have received pass-through status for reporting drugs and biologicals in the hospital outpatient setting. These new codes are in Table 4.

### Table 4: Codes Receiving Pass-Through Status

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3111</td>
<td>Injection, romosozumab-aqqg, 1 mg</td>
<td>G</td>
<td>9327</td>
</tr>
<tr>
<td>J9356</td>
<td>Injection, trastuzumab, 10 mg and Hyaluronidase-oysk</td>
<td>G</td>
<td>9314</td>
</tr>
</tbody>
</table>

#### b. Separately Payable Drugs and Biologicals that Will Receive Pass-Through Status (Status Indicator = “G”) for the Period of April 1, 2019, Through June 30, 2019

The status indicator for HCPCS code C9042 (Injection, bendamustine hcl (belrapzo), 1 mg) for the period of April 1, 2019, through June 30, 2019, will be changed retroactively from status indicator = “E2” to status indicator = “G.” This drug is in Table 5.

### Table 5: C9042 Updated Status Indicator

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Old SI</th>
<th>New SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9042</td>
<td>Injection, bendamustine hcl (belrapzo), 1 mg</td>
<td>E2</td>
<td>G</td>
<td>9313</td>
</tr>
</tbody>
</table>

#### c. Drugs and Biologicals that Will Change from Non-Payable Status (Status Indicator = “E2”) to Separately Payable Status (Status Indicator = “K”) for the Period of July 18, 2019, through September 30, 2019

The status indicator for HCPCS code Q5107 (Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg) for the period of July 18, 2019, through September 30, 2019, will be changed retroactively from status indicator = “E2” to status indicator = “K.” This drug is in Table 6.

### Table 6: Q5107 Updated Status Indicator

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Old SI</th>
<th>New SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5107</td>
<td>Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg</td>
<td>E2</td>
<td>K</td>
<td>9329</td>
</tr>
</tbody>
</table>

#### d. New Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of October 1, 2019

There are 45 new drug, biological, and radiopharmaceutical HCPCS codes that will be established on October 1, 2019. The new codes are in Table 7.

### Table 7: New Drug, Biological, and Radiopharmaceutical Codes to be Established on October 1, 2019

<table>
<thead>
<tr>
<th>New HCPCS Code</th>
<th>Old HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1943</td>
<td>C9035</td>
<td>Injection, aripiprazole lauroxil (aristada initio), 1 mg</td>
<td>G</td>
<td>9179</td>
</tr>
<tr>
<td>J0222</td>
<td>C9036</td>
<td>Injection, Patisiran, 0.1 mg</td>
<td>G</td>
<td>9180</td>
</tr>
<tr>
<td>J2798</td>
<td>C9037</td>
<td>Injection, risperidone, (perseris), 0.5 mg</td>
<td>G</td>
<td>9181</td>
</tr>
<tr>
<td>J9204</td>
<td>C9038</td>
<td>Injection, mogamulizumab-kpkc, 1 mg</td>
<td>G</td>
<td>9182</td>
</tr>
<tr>
<td>J0291</td>
<td>C9039</td>
<td>Injection, plazomicin, 5 mg</td>
<td>G</td>
<td>9183</td>
</tr>
<tr>
<td>J3031</td>
<td>C9040</td>
<td>Injection, fremanezumab-vfrm, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)</td>
<td>G</td>
<td>9197</td>
</tr>
<tr>
<td>J0641(1)</td>
<td></td>
<td>Injection, levoeleucovorin, not otherwise specified, 0.5 mg</td>
<td>K</td>
<td>1236</td>
</tr>
<tr>
<td>J0642</td>
<td></td>
<td>Injection, Levoeleucovorin (khapzory), 0.5 mg</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>J9119</td>
<td>C9044</td>
<td>Injection, cemiplimab-rwlc, 1 mg</td>
<td>G</td>
<td>9304</td>
</tr>
<tr>
<td>J9313</td>
<td>C9045</td>
<td>Injection, mogamulizumab-pasudotox-tdfk, 0.01 mg</td>
<td>G</td>
<td>9305</td>
</tr>
<tr>
<td>J1096</td>
<td>C9048</td>
<td>Dexamethasone, lacrimal ophthalmic insert, 0.1 mg</td>
<td>G</td>
<td>9308</td>
</tr>
<tr>
<td>J9269</td>
<td>C9049</td>
<td>Injection, tagraxofusp-erzs, 10 micrograms</td>
<td>G</td>
<td>9309</td>
</tr>
<tr>
<td>J9210</td>
<td>C9050</td>
<td>Injection, emapalumab-lzsg, 1 mg</td>
<td>G</td>
<td>9310</td>
</tr>
</tbody>
</table>
### Table 7: New Drug, Biological, and Radiopharmaceutical Codes to be Established on October 1, 2019

<table>
<thead>
<tr>
<th>New HCPCS Code</th>
<th>Old HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0121</td>
<td>C9051</td>
<td>Injection, omadacycline, 1 mg</td>
<td>G</td>
<td>9311</td>
</tr>
<tr>
<td>J103</td>
<td>C9052</td>
<td>Injection, ravulizumab-cwvz, 10 mg</td>
<td>G</td>
<td>9312</td>
</tr>
<tr>
<td>J1097</td>
<td>C9447</td>
<td>phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml</td>
<td>G</td>
<td>9324</td>
</tr>
<tr>
<td>J0122</td>
<td></td>
<td>Injection, evacacycline, 1 mg</td>
<td>K</td>
<td>9325</td>
</tr>
<tr>
<td>J0593</td>
<td></td>
<td>Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)</td>
<td>K</td>
<td>9326</td>
</tr>
<tr>
<td>J1944</td>
<td>J1942</td>
<td>Injection, aripiprazole lauroxl, (aristada), 1 mg</td>
<td>K</td>
<td>9470</td>
</tr>
<tr>
<td>J7314</td>
<td></td>
<td>Injection, fluocinolone acetoneide, intravitreal implant (Yutiq), 0.01 mg</td>
<td>K</td>
<td>9328</td>
</tr>
<tr>
<td>J7331</td>
<td></td>
<td>Hyaluronan or derivative, synojoynt, for intra-articular injection, 1 mg</td>
<td>E2</td>
<td>N/A</td>
</tr>
<tr>
<td>J7332</td>
<td></td>
<td>Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg</td>
<td>E2</td>
<td>N/A</td>
</tr>
<tr>
<td>J9118</td>
<td></td>
<td>Injection, calaspargase pegol-mknl, 10 units</td>
<td>E2</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4205</td>
<td></td>
<td>Membrane graft or membrane wrap, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4206</td>
<td></td>
<td>Fluid flow or fluid GF, 1 cc</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4208</td>
<td></td>
<td>Novafix, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4209</td>
<td></td>
<td>Surgraft, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4210</td>
<td></td>
<td>Axolotl graft or axolotl dualgraft, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4211</td>
<td></td>
<td>Amnion bio or Axobiomembrane, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4212</td>
<td></td>
<td>Allogen, per cc</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4213</td>
<td></td>
<td>Ascent, 0.5 mg</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4214</td>
<td></td>
<td>Cellesta cord, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4215</td>
<td></td>
<td>Axolotl ambient or axolotl cryo, 0.1 mg</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4216</td>
<td></td>
<td>Artacent cord, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4217</td>
<td></td>
<td>Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or BioWound Xplus, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4218</td>
<td></td>
<td>Surgicord, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4219</td>
<td></td>
<td>Surgigraft-dual, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4220</td>
<td></td>
<td>BellaCell HD or Surederm, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4221</td>
<td></td>
<td>Amniowrap2, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4222</td>
<td></td>
<td>Progenamatrix, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4226</td>
<td></td>
<td>MyOwn skin, includes harvesting and preparation procedures, per square centimeter</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q5107</td>
<td></td>
<td>Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg</td>
<td>K</td>
<td>9329</td>
</tr>
<tr>
<td>Q5116</td>
<td></td>
<td>Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg</td>
<td>E2</td>
<td>N/A</td>
</tr>
<tr>
<td>Q5117</td>
<td></td>
<td>Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg</td>
<td>K</td>
<td>9330</td>
</tr>
<tr>
<td>Q5118</td>
<td></td>
<td>Injection, bevacizumab-bvcr, biosimilar, (Zirabev), 10 mg</td>
<td>E2</td>
<td>N/A</td>
</tr>
<tr>
<td>J7401</td>
<td>S1090</td>
<td>Mometasone furoate sinus implant, 10 micrograms</td>
<td>N</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(1) HCPCS J0641 is not new for October 1, 2019, but please note that the long descriptor has changed for J0641, effective October 1, 2019.

#### e. Ambulatory Payment Classification (APC) Assignment Change for HCPCS code J9030, BCG live intravesical instillation, 1 mg, Effective July 1, 2019, in the October 2019 I/OCE Release

See Table 8 for the APC assignment change for HCPCS code, J9030, effective July 1, 2019, in the October 2019 I/OCE Release.
Table 8: J9030 – APC Assignment Change

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Old APC Assignment</th>
<th>New APC Assignment</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9030</td>
<td>BCG live intravesical instillation, 1 mg</td>
<td>0809</td>
<td>9322</td>
<td>07/01/19</td>
</tr>
</tbody>
</table>

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

For CY 2019, payment for nonpass-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.

Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later-quarter ASP submissions become available. Effective October 1, 2019, payment rates for some drugs and biologicals have changed from the values published in the July 2019 update of the OPPS Addendum A and Addendum B. CMS is not publishing the updated payment rates in this CR implementing the October 2019 update of the OPPS. However, the updated payment rates effective October 1, 2019, can be found in the October 2019 update of the OPPS Addendum A and Addendum B on the CMS website at [http://www.cms.gov/HospitalOutpatientPPS/](http://www.cms.gov/HospitalOutpatientPPS/).

g. 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 CMS website on the first date of the quarter at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/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.

5. Clarification on the Guidance for Intraocular or Periocular Injections of Combinations of Anti-Inflammatory Drugs and Antibiotics

On September 15, 2015, CMS issued CR 9298 (Transmittal R3352CP), which provided guidance for “dropless cataract surgery.” (See related MLN Matters article at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9298.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9298.pdf). CR 11451 is a clarification to CR 9298 on “dropless cataract surgery.” Intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics are being used with increased frequency in ocular surgery (primarily cataract surgery). One example of combined or compounded drugs includes, triamcinolone and moxifloxacin with or without vancomycin. Such combinations may be administered as separate injections or as a single combined injection. Because such injections may obviate the need for post-operative anti-inflammatory and antibiotic eye drops, some have referred to cataract surgery with such injections as “dropless cataract surgery.” However, nothing in this CR is intended to preclude physicians or other professionals from discussing the potential benefits and drawbacks of dropless therapy with their patients and prescribing it if the patient so elects.

6. OPPS Pricer logic and data changes for October

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

7. 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 it is excluded from payment.

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 of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 5, 2019</td>
<td>We revised this article to clarify that the providers affected are institutional providers. All other information remains the same.</td>
</tr>
<tr>
<td>October 7, 2019</td>
<td>We revised this article to reflect the revised CR 11451, issued on October 4, 2019. CMS revised the CR to correct Table 7 to reinstate C9043 rather than delete it effective October 1, 2019. CR11451 also added a new HCPCS code J0642, which is effective October 1, 2019, and revised the descriptor for J0641. The CR release date, transmittal number, and the web address of the CR are changed. All other information remains the same.</td>
</tr>
<tr>
<td>September 3, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

FOR HOME HEALTH AND HOSPICE PROVIDERS

MM11453: Medicare Physician Fee Schedule Database (MPFSDB) Update to Status Indicators

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/index

<table>
<thead>
<tr>
<th>MLN Matters Number: MM11453</th>
<th>Related CR Release Date: October 18, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Transmittal Number: R4418CP</td>
<td>Related Change Request (CR) Number: 11453</td>
</tr>
<tr>
<td>Effective Date: January 1, 2020</td>
<td>Implementation Date: November 19, 2019</td>
</tr>
</tbody>
</table>

PROVIDER TYPE AFFECTED

This MLN Matters Article is for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for therapy services to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11453 informs MACs that Status Indicator Q (therapy functional information code) is no longer effective with the 2020 MPFSDB beginning January 1, 2020. Medicare no longer requires functional therapy reporting. CR 11453 makes change to the Medicare Claims Processing Manual, Chapter 23, Section 30.2.2 to reflect this change for Status Indicator Q. Make sure that your billing staffs are aware of this change.
ADDITONAL 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.

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FOR HOME HEALTH AND HOSPICE PROVIDERS

MM11467: Claim Status Category and Claim Status Codes Update

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/index

MLN Matters Number: MM11467
Related CR Transmittal Number: R4460CP
Effective Date: April 1, 2020
Related CR Release Date: November 15, 2019
Related Change Request (CR) Number: 11467
Implementation Date: April 6, 2020

PROVIDER TYPE 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

CR 11467 updates 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 staff is 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 ASC X12 276/277 Health Care Claim Status Request and Response transaction standards. These standards were adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claims. 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 six (6) months for implementation of newly added or changed codes.

status-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 2020 committee meeting shall be posted on these sites on or about March 1, 2020.

The Centers for Medicare & Medicaid Services (CMS) will issue future updates to these codes as needed. MACs must update their claims systems to ensure the current version of these codes is used in their claim status responses. MAC and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as the retirement of previously used codes or newly created codes.

These code changes are to be used in the editing of all ASC X12 276 transactions processed on or after the date of implementation. These code changes are also to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 11467.

The MACs must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, including the ASC X12 276/277 Health Care Claim Status Request and Response. These contractors 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.

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


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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FOR HOME HEALTH AND HOSPICE PROVIDERS

**MM11489**: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

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/index

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<th>MLN Matters Number: MM11489</th>
<th>Related CR Release Date: November 15, 2019</th>
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<tr>
<td>Related CR Transmittal Number: R4461CP</td>
<td>Related Change Request (CR) Number: 11489</td>
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<tr>
<td>Effective Date: April 1, 2020</td>
<td>Implementation Date: April 6, 2020</td>
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PROVIDER TYPE 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
CR 11489 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes and obtain the updated MREP and PC Print if they use that 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 requires 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, 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 that results in publication three times per year – around March 1, July 1, and November 1.

CR 11489 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. The Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. The SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date later than the implementation date specified in CR 11489, MACs must implement on the date specified on the WPC website (http://wpc-edi.com/Reference/).

A discrepancy between the dates may arise, as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR 11489, MACs and SSMs must get the complete list for both CARC and RARC from the WPC 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 (CR11252 with related article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11252.pdf).

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.

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**MM11490: 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/index](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index)

**MLN Matters Number:** MM11490  
**Related CR Transmittal Number:** R4463CP  
**Effective Date:** April 1, 2020  
**Related CR Release Date:** November 15, 2019  
**Related Change Request (CR) Number:** 11490  
**Implementation Date:** April 6, 2020

**PROVIDER TYPE 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**
CR 11490 instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (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 scheduled to be published on or about February 1, 2020. Make sure your billing staffs are aware of these updates.

**BACKGROUND**
The Department of Health & Human Services (HHS) adopted the Phase III CAQH CORE, EFT and 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 of the Act, requiring the Secretary of HHS (the Secretary) 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.

CR 11490 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, 2020. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2019. This will also include updates based on market-based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare, as the industry needs them.
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.

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For Home Health and Hospice Providers

MM11501: 2020 Annual Update to the Therapy Code List

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/index

MLN Matters Number: MM11501
Related CR Transmittal Number: R4421CP
Effective Date: January 1, 2020

Related CR Release Date: October 25, 2019
Related Change Request (CR) Number: 11501
Implementation Date: January 6, 2020

Provider Type Affected

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

Provider Action Needed

CR 11501 updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the Calendar Year (CY) 2020 Current Procedural Terminology (CPT) and Level II HCPCS. Make sure your billing staffs are aware of these updates.

Background

Section 1834(k)(5) of the Social Security Act requires all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The CY 2020 CPT and Level II HCPCS is the coding system used for reporting these services. The therapy code listing is available at http://www.cms.gov/Medicare/Billing/TherapyServices/index.html.
CR 11501 implements policies discussed in CY 2020 Medicare Physician Fee Schedule (MPFS) rulemaking. The CR updates the therapy code list and associated policies for CY 2020, as follows:

1. The CPT Editorial Panel created two new biofeedback codes to replace CPT code 90911. The Centers for Medicare & Medicaid Services (CMS) designated these new codes as “sometimes therapy” to permit physicians and Non-Physician Practitioners (NPPs), including nurse practitioners, physicians assistants, and certified nurse specialists to furnish these services outside a therapy plan of care when appropriate. However, when furnished to hospital outpatients, these two new biofeedback services will continue to be paid under the Outpatient Prospective Payment System (OPPS). The two new “sometimes therapy” codes with their CPT long descriptors, are as follows:
   - **CPT code 90912** - Biofeedback training, perineal muscles, anorectal or urethral sphincter, including electromyography (EMG) and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient
   - **CPT code 90913** - Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)

2. The CPT Editorial Panel also created, for CY 2020; CPT codes 97129 and 97130 to replace CPT code 97127, which CMS did not recognize. These new codes will effectively replace HCPCS code G0515, which will be deleted, effective January 1, 2020. These codes are designated “sometimes therapy” to permit physicians, NPPs, and psychologists to furnish these services outside a therapy plan of care when appropriate. The CPT long descriptors for the two new “sometimes therapy” codes are:
   - **CPT code 97129** - Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
   - **CPT code 97130** - Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)

3. The CPT Editorial Panel also deleted the following codes for manual muscle testing for CY 2020: CPT codes 95831, 95832, 95833, and 95834.

4. The following 42 HCPCS Level II G-codes are deleted for dates of service after December 31, 2019:
   - HCPCS codes G8978 through G8999; G9158 through G9176; and G9186
   These codes were used for Functional Reporting of therapy services for CY 2013 through 2018 but were retained for CY 2019 as discussed in the CY 2019 MPFS final rule at 83 FR 59661.

**Note:** CPT codes 0019T and 64550 are being removed from prior years, 2017 and 2019, respectively.

**ADDITIONAL INFORMATION**

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.
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**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>
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<tr>
<th>Date</th>
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<tr>
<td>Thursday, January 9, 2020</td>
<td>PCC Training, 8:00 – 10:00 a.m. Central Time</td>
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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](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](https://www.cgsmedicare.com/hhh/index.html) and click the “myCGS” button on the left side of the Web page.


**FOR HOME HEALTH AND HOSPICE PROVIDERS**

**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 nonregulatory changes to Medicare including transmittals, 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; and
- Communicate the specific days that CMS business will be published in the Federal Register.

Stay Informed and Join the CGS ListServ Notification Service

The CGS ListServ Notification Service is the primary means used by CGS to communicate with home health and hospice Medicare providers. This is a free email notification service that provides you with prompt notification of Medicare news including policy, benefits, claims submission, claims processing and educational events. Subscribing for this service means that you will receive information as soon as it is available, and plays a critical role in ensuring you are up-to-date on all Medicare information.

Consider the following benefits to joining the CGS ListServ Notification Service:

- It’s free! There is no cost to subscribe or to receive information.
- You only need a valid e-mail address to subscribe.
- Multiple people/e-mail addresses from your facility can subscribe. We recommend that all staff (clinical, billing, and administrative) who interact with Medicare topics register individually. This will help to facilitate the internal distribution of critical information and eliminates delay in getting the necessary information to the proper staff members.

To subscribe to the CGS ListServ Notification Service, go to http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp and complete the required information.

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.

Link to the survey monkey will be provided when the final bulletin document is submitted via COPE.