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Medicare Bulletin

JURISDICTION 15

PART A • PART B • HOME HEALTH & HOSPICE

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CGS
A CELERIAN GROUP COMPANY

GR 2020-12
ORIGINATED NOVEMBER 17, 2020

Medicare Bulletin

Jurisdiction 15

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THE MEDICARE LEARNING NETWORK®

A Valuable Educational Resource!

The Medicare Learning Network® (MLN), offered by the Centers for Medicare & Medicaid Services (CMS), includes a variety of educational resources for health care providers. Access Web-based training courses, national provider conference calls, materials from past conference calls, MLN articles, and much more.

Learn more about what the CMS MLN offers at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html on the CMS Website.

CGS Contact Information

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center (PCC) at the following numbers listed below. Listen carefully and choose the option most appropriate for the reason you are calling.

PART A - 1.866.590.6703

Options

- 1 – Claims
- 2 – Electronic Data Interchange (EDI)
- 3 – Provider Enrollment
- 4 - Overpayment Recovery
- 9 – General Inquiries

PART B - 1.866.276.9558

Options

- 1 – Claims
- 2 – Electronic Data Interchange (EDI
- 3 – Provider Enrollment
- 4 - Telephone Reopening
- 5 – Overpayment Recovery (OPR)
- 9 – General Inquiries

HOME HEALTH AND HOSPICE - 1.877.299.4500

Options

- 1 – Claims
- 2 – Electronic Data Interchange (EDI)
- 3 – Provider Enrollment
- 4 – Overpayment Recovery
- 9 – General Inquiries

Access the "Contact Information" Web pages for information about the Interactive Voice Response (IVR) system, as well as telephone numbers, fax numbers, and mailing addresses for other CGS departments.

- **Part A -** https://www.cgsmedicare.com/parta/cs/index.html
- **Part B -** https://www.cgsmedicare.com/partb/cs/index.html
- **Home Health and Hospice -** https://www.cgsmedicare.com/hhh/cs/index.html

BEFORE YOU CALL

Access the following resources that may be able to answer your questions:

Part A

- How Do I…?" (https://www.cgsmedicare.com/parta/cs/howdoi.html)
- Education & Events" (https://www.cgsmedicare.com/parta/education/index.html)

Part B

- How Do I…?" (https://www.cgsmedicare.com/partb/cs/howdoi.html)
- Education & Events" (https://www.cgsmedicare.com/partb/education/index.html)

Home Health and Hospice

- "How Do I…?" (https://www.cgsmedicare.com/hhh/cs/howdoi.html)
- "Education & Resources" (https://www.cgsmedicare.com/hhh/education/index.html)

https://www.cgsmedicare.com/mycgs/index.html

myCGS is a secure Internet-based application where you can view beneficiary eligibility, claims status, online remittances, financial information, and much more!

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FOR ALL PROVIDERS

Google Authenticator:
A New Way to Access myCGS!

Multi-factor Authentication (MFA) is the additional level of security myCGS requires before users can gain access to the portal. Instead of receiving your MFA code via text or email, you may now use the Google Authenticator app on your mobile devices! The app is available for download in the App Store (Apple) and Android Play Store (Android). Go to https://www.cgsmedicare.com/hhh/pubs/news/2020/10/cope19154.html for complete details to install Google Authenticator and link it to myCGS.

FOR ALL PROVIDERS

MLN Connects® Weekly News

The MLN Connects®, available at https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive is the official news from the Medicare Learning Network and contains a weeks' worth of current Medicare-related messages. These messages are delivered timely about Medicare-related topics. Please share with appropriate staff. If you wish to receive the listserv directly from CMS, refer to https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Electronic-Mailing-Lists.

FOR ALL PROVIDERS

MLN Matters Disclaimer Statement

The CMS Medicare Learning Network (MLN) Matters articles are prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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FOR ALL PROVIDERS

MM11939 (Revised): Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2020 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: MM11939 Revised
Related CR Release Date: October 27, 2020
Related CR Transmittal Number: R10408CP

Related Change Request (CR) Number: 11939
Effective Date: January 1, 2020
Implementation Date: October 5, 2020

Note: We revised the article to reflect the revised CR11939, issued on October 27, 2020. We added information about codes 3170F, 0599T, A4226, and the new codes 86408, 86409, 86413, and 99072. Also, we revised the CR release date, transmittal number, and the Web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries and which are paid under the Medicare Physician Fee Schedule (MPFS).

PROVIDER ACTION NEEDED

This article informs you about the issuance of updated payment files in the October update of the 2020 MPFS. Make sure your billing staffs are aware of these updates.

The complete MM11939 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/mm11939.pdf.

If you have questions, contact the CGS Provider Contact Center at the appropriate number listed below and choose Option 1.

Part A:	1.866.590.6703	**Part B:**	1.866.276.9558	**Home Health and Hospice:**	1.877.299.4500

FOR ALL PROVIDERS

MM11956 (Revised): October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

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: MM11956 Revised
Related CR Release Date: October 27, 2020
Related CR Transmittal Number: R10410CP

Related Change Request (CR) Number: 11956
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

Note: We revised this article to reflect the revised CR11956, issued on October 27, 2020. The CR revision clarified the claims processing jurisdiction for code K1009 and we made that clarification in this article. Also, we revised the CR release date, the transmittal number, and the Web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics

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and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule for Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11956 informs DME MACs about the changes to the DMEPOS fee schedules that Medicare updates quarterly, when necessary, to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. Make sure your billing staffs are aware of these changes.

The complete MM11956 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/mm11956.pdf.

If you have questions, contact the CGS Provider Contact Center at the appropriate number listed below and choose Option 1.

Part A:	1.866.590.6703	**Part B:**	1.866.276.9558	**Home Health and Hospice:**	1.877.299.4500

FOR ALL PROVIDERS

MM12020: January 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

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: MM12020
Related CR Release Date: October 9, 2020
Related CR Transmittal Number: R10391CP
Related Change Request (CR) Number: 12020
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Part B Drugs provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article informs you of updates to the Quarterly Average Sales Price (ASP) Medicare Part B Pricing Files and informs providers of revisions, if needed, to prior quarterly pricing files. Please make sure your billing staffs are aware of these updates and revisions.

The complete MM12020 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/mm12020.pdf.

If you have questions, contact the CGS Provider Contact Center at the appropriate number listed below and choose Option 1.

Part A:	1.866.590.6703	**Part B:**	1.866.276.9558	**Home Health and Hospice:**	1.877.299.4500

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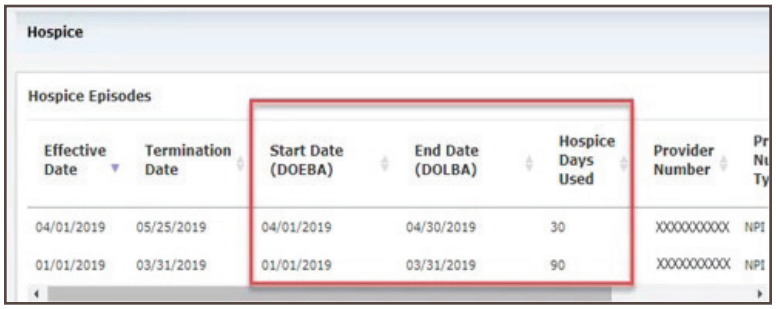
FOR ALL PROVIDERS

myCGS Now Offers MORE Hospice Information!

A recent myCGS enhancement now allows you access to additional hospice details. Under the Eligibility tab / Home Health & Hospice sub-tab, you can now view:

- Date of Earliest Billing Activity (DOEBA)
- Date of Latest Billing Activity (DOLBA)
- Up to 50 billed Hospice episodes that occurred in the last four years
- The number of Hospice days used



Take advantage of this enhancement and a number of additional myCGS functions available to you at https://www.cgsmedicare.com/mycgs/mycgs_user_manual.html.

Not currently using myCGS? Go to https://www.cgsmedicare.com/mycgs/index.html and Register TODAY!

FOR ALL 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 Part A PCC (**1.866.590.6703**), Part B PCC (**1.866.276.9558**) and the home health and hospice PCC at **1.877.299.4500** (option 1) will be closed for training.

Date	PCC Training/Closures
Thursday, December 10, 2020	• PCC Closed: 8:00 – 10:00 a.m. Central Time • PCC Closed: 9:00 – 11:00 a.m. Eastern Time

Note: While we celebrate the holidays with our families, our office will be closed on Thursday, December 24 and Friday, December 25, 2020, as well as Friday, January 1, 2020.

The Interactive Voice Response (IVR) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. In addition, CGS' Internet portal, myCGS (https://www.cgsmedicare.com/mycgs/index.html), is available to access various eligibility information through the Internet.

PART A IVR - 1.866.289.6501

- IVR User Guide https://www.cgsmedicare.com/parta/cs/cgs_j15_parta_ivr_user_guide.pdf

PART B IVR – 1.866.290.4036

- IVR User Guide at https://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf

HOME HEALTH AND HOSPICE IVR - 1.877.220.6289

- IVR User Guide https://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf

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SE20011 (Revised): Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

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: SE20011 Revised
Article Release Date: October 16, 2020
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Note: We revised the article to clarify the HCPCS codes that Critical Access Hospitals (CAHs) should use in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. Also, we clarified the Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information section to show the SNF waiver applies to swing-bed services in rural hospitals and CAHs. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is for physicians, providers and suppliers who bill Medicare Fee-For-Service (FFS).

PROVIDER INFORMATION AVAILABLE

The Secretary of the Department of Health & Human Services declared a public health emergency (PHE) in the entire United States on January 31, 2020. On March 13, 2020 Secretary Azar authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to March 1, 2020.

The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

More Information:

- Coronavirus Waivers and Flexibilities Web page, https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
- Instructions to request an individual waiver if there is no blanket waiver, https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf

The complete SE20011 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/SE20011.pdf.

If you have questions, contact the CGS Provider Contact Center at the appropriate number listed below and choose Option 1.

Part A:	1.866.590.6703	**Part B:**	1.866.276.9558	**Home Health and Hospice:**	1.877.299.4500

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FOR ALL PROVIDERS

Stay Informed and Join the CGS ListServ Notification Service

The CGS Listserv Notification Service is the primary means used by CGS to communicate with Kentucky and Ohio Medicare Part A, Part B, and Home Health & Hospice providers. The Listserv 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 interacts 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 https://www.cgsmedicare.com/listserv.html and complete the required information.

FOR ALL PROVIDERS

Upcoming Educational Events

The CGS Provider Outreach and Education (POE) department offers educational events through Webinars and teleconferences throughout the year. Registration for these events is required. For upcoming events, please refer to the Calendar of Events.

- Part A Calendar of Events - https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/parta_report/parta_report.aspx
- Part B Calendar of Events - https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/partb_report/partb_report.aspx
- Home Health and Hospice Calendar of Events - https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/hhh_report/hhh_report.aspx

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_PartA_Education@cgsadmin.com, J15_PartB_Education@cgsadmin.com, or J15_HHH_Education@cgsadmin.com.

FOR ALL PROVIDERS

Voluntary Refunds

As you know, providers may at times receive an incorrect payment (e.g., for services/items not covered, erroneously billed, etc.). When this happens, the overpayment is a debt due the Medicare program.

Medicare expects providers to exercise care when billing and accepting payment and expects that providers will promptly bring incorrect payments to the carrier's attention. These submissions acknowledge your awareness of this expectation and confirms a measure of compliance. However, please be aware that the CMS Online Manual, Publication 100-08, Chapter 4, Section 4.16 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04.pdf) states:

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

Thank you for your efforts to work in cooperation with CGS Administrators, LLC to ensure proper and appropriate delivery of Medicare benefits. If you have any questions, please contact our office at one of the following numbers.

CGS Jurisdictions/States	Customer Service Number
Jurisdiction 15 Providers	
Part A/KY & OH	1.866.590.6703
Part B/KY & OH	1.866.276.9558
Home Health & Hospice	
CO, DC, DE, IA, KS, MD, MO, MT, ND, NE, PA, SD, UT, VA, WV, & WY	1.877.299.4500

FOR PART A AND PART B PROVIDERS

Botulinum Toxins Billing and Coding Article (A56472) Revision

There were errors in grouping within the Botulism Toxins article that were identified and corrected.

A summary of the changes are as follows:

1. All migraine codes and disorders of the facial nerve are consolidated in Group 5.
2. 64615 was not listed in the group codes and was added to Group 5 Paragraph.
3. Spastic entropion of eyelid was moved to Group 11 (eye muscle group), and migraine codes were removed from this group.
4. Larynx and non- larynx were separated, and codes specific to injection in the larynx placed in Group 7. 31573 were added to the CPT list and Group 7.
5. Group 12 was deleted as all migraine codes are now condensed to Group 5 (Migraine/facial nerve codes). Codes for laryngeal spasm were removed from this group and now in Group 7.
6. Groups re-numbers to reflect these changes.

There was no change in coverage in this revision. No ICD-10 codes were removed or added. The changes were to correct the grouping errors that were identified.

FOR PART A AND PART B PROVIDERS

Help Stop Delays!!!!!!

Providers, ever wonder why there is a delay in crediting your account if you send it via check? Well, where you are sending it may be the issue. Every line of business (Part A, Part B, and HH&H) has a unique PO Box for checks to be mailed to. Part A and Part B even have unique PO Boxes specific for each state! When checks are sent to the wrong address, they cause severe delays in proper processing and can even cause returns. So, before you put that check in the mail, visit the Overpayment and Refunds section of our Website for your line of business, click on the Refund Check widget, and verify that address!

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FOR PART A AND PART B PROVIDERS

MM11659: Special Provisions for Radiology Additional Documentation Requests

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: MM11659
Related CR Release Date: October 30, 2020
Related CR Transmittal Number: R10412OTN
Related Change Request (CR) Number: 11659
Effective Date: December 1, 2020
Implementation Date: December 1, 2020

PROVIDER TYPE AFFECTED

This MLN Matters® Article is for physicians, other providers, and suppliers submitting claims or documentation to Medicare Administrative Contractors (MACs) related to radiology services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article discusses a pilot process enabling MACs to request pertinent documentation from the treating/ordering provider during medical review, in an effort to support the necessity and payment for radiology service(s)/item(s) billed to Medicare. Make sure that your billing staffs are aware of these changes.

The complete MM11659 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/MM11659.pdf.

If you have questions, contact the CGS Provider Contact Center at the appropriate number listed below and choose Option 1.

Part A:	1.866.590.6703	**Part B:**	1.866.276.9558

FOR PART A AND PART B PROVIDERS

MM12031: Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2021 and Productivity Adjustment

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: MM12031
Related CR Release Date: October 16, 2020
Related CR Transmittal Number: R10396CP
Related Change Request (CR) Number: 12031
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

PROVIDER TYPE AFFECTED

This MLN Matters Article is for ambulance providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Medicare Part B ambulance services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

This article gives you the Calendar Year (CY) 2021 Ambulance Inflation Factor (AIF) for determining the payment limit for ambulance services. The AIF for CY 2021 is 0.2 percent. Make sure that your billing staffs are aware of this change.

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The complete MM12031 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/MM12031.pdf.

If you have questions, contact the CGS Provider Contact Center at the appropriate number listed below and choose Option 1.

Part A:	1.866.590.6703	**Part B:**	1.866.276.9558

FOR PART A, HOME HEALTH AND HOSPICE PROVIDERS

MM11944 (Revised): October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3

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: MM11944 Revised
Related CR Release Date: October 2, 2020
Related CR Transmittal Number: R10382CP
Related Change Request (CR) Number: 11944
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

Note: We revised this article to reflect the revised CR 11944, issued on October 2, 2020. The CR revision added several items to the Summary of Quarterly Release Modifications table, and we made those same changes in the article. Also, we revised the CR release date, transmittal number, and the Web address of the CR. All other information is the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article discusses changes to the October 2020 version of the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that Medicare uses

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

Make sure your billing staffs are aware of these changes.

The complete MM11944 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/MM11944.pdf.

If you have questions, contact the CGS Provider Contact Center at the appropriate number listed below and choose Option 1.

Part A:	1.866.590.6703	**Home Health and Hospice:**	1.877.299.4500

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MM11960 (Revised): October 2020 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: MM11960 Revised
Related CR Release Date: September 24, 2020
Related CR Transmittal Number: R10373CP

Related Change Request (CR) Number: 11960
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

Note: We revised this article to reflect an updated CR 11960 that made a number of changes including:

1. Added a new COVID-19 CPT code, 86413, to Table 1
2. Added new Section 2: "New Category I CPT code 99072 for Reporting of Additional Practice Expenses Incurred During a Public Health Emergency (PHE), Including Supplies and Additional Clinical Staff Time."
3. Added new Table 2, with the new 99072 CPT code.
4. Re-numbered all sections after Section 2 and all the tables following Table 2.
5. Added a new Sub-section e. to Section 8: "Drugs, Biologicals, and Radiopharmaceuticals."
6. Added New Table 12 to describe these changes. All sub-sections following new Sub-section e. were re-numbered.
7. Updated Sub-section g. and Table 14 to reflect the change to the long descriptor for HCPCS, C9066.
8. Updated Tables 8 and 13 to reflect the correct long descriptor for C9066.

The CR release date, transmittal number and link to the transmittal was also changed. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article informs you about the changes to and billing instructions for various payment policies implemented in the October 2020 Outpatient Prospective Payment System (OPPS) update. The October 2020 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 11960. The October 2020 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming October 2020 I/OCE CR. Make sure that your billing staffs are aware of these changes.

The complete MM11960 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/MM11960.pdf.

If you have questions, contact the CGS Provider Contact Center at the appropriate number listed below and choose Option 1.

Part A:	1.866.590.6703	**Home Health and Hospice:**	1.877.299.4500

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Top Claim Submission Errors: Duplicate Claims and Requests for Anticipated Payment (RAPs)

Did you know how often duplicate claims are received by CGS and rejected? The submission of home health and hospice (HHH) duplicate claims and home health agency (HHA) duplicate RAPs are consistently top reject reasons for CGS. Data shows that from April-September 2020, there were a total of 55,346 duplicate claims and RAPs. During this period, 8,520 claims rejected with reason code 38200 and 46,826 RAPs rejected with reason code 38157. During this same period for 2019, there were a total of 23,097 duplicate claims/RAPs (10,848 claims and 12,249 RAPs). **That's a 140% increase!**

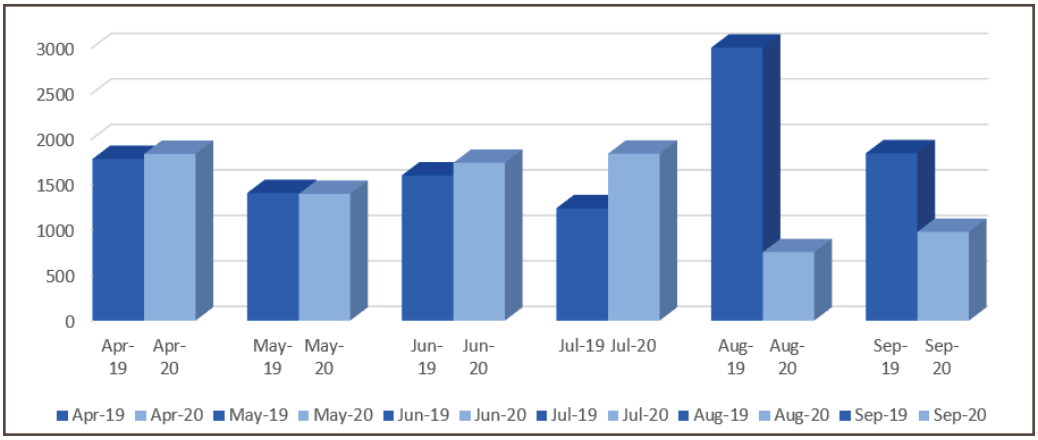
It is important for providers to be aware that duplicate billing errors impact the Medicare program negatively by increasing the cost to process Medicare claims. Providers are also negatively impacted by the consequences of duplicate billing such as:

- Payment delays,
- Identification as an abusive biller, or
- The initiation of a fraud investigation if a pattern of duplicate billing is identified.

Reason Code 38200 – Claims will reject when the submitted claim is an exact duplicate of a previously submitted claim where the following fields are the same:

- Medicare Beneficiary Identifier (MBI)
- Type of Bill
- Provider Number
- Statement From and Through dates
- Total Charges
- Revenue Code
- HCPCS and modifiers (if required)

38200 Duplicate Claims Comparison Between 2019 and 2020



Reason Code 38157 – Home health RAPs will reject when the submitted RAP is a duplicate of a paid RAP, or a suspended or denied home health claim with the same provider number, MBI and statement From date, but without a cancel date. The RAP may also reject when the RAP and final claim are submitted at the same time. Always wait to submit the final claim until the RAP has finalized and is in status/location P B9997.

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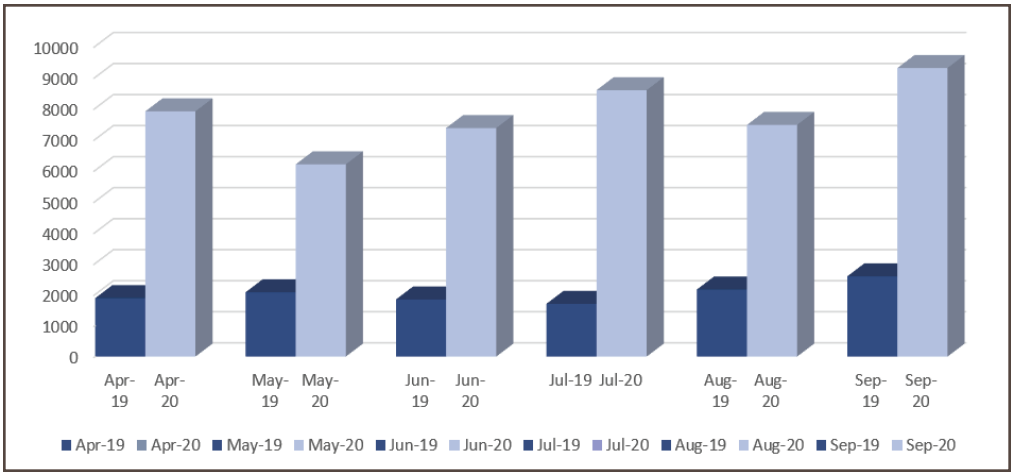
38157 - RAPs Comparison Between 2019 and 2020



TIPS TO AVOID DUPLICATE BILLING

- When using batch file transfer software, have an internal procedure in place to ensure batches of billing transactions are deleted from the software once they are submitted to Medicare.
- Review Medicare Remittance Advice timely.
- Stay current in posting payments received from Medicare.
- Access the FISS Claim Inquiry Option (Option 12) to determine which claims have been submitted to Medicare. For instructions on using FISS Inquiry Option 12, see Chapter 3 - Inquiry Menu of the *Fiscal Intermediary Standard System (FISS) Guide* at https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_3-inquiry_menu.pdf.
- Do not resubmit an identical billing transaction if you have already corrected the claim from the Return to Provider (RTP) file.
  - We encourage you to suppress the view of claims in your RTP file that you do not intend to correct. See Chapter 5 - Claims Correction of the *Fiscal Intermediary Standard System (FISS) Guide* at https://www.cgsmedicare.com/hhh/education/materials/pdf/chapter_5-claims_correction_menu.pdf for instructions on suppressing the view of claims in RTP.
- When appropriate, adjust rejected (R B9997) or paid (P B9997) claims instead of resubmitting them.

Please share this information with your billing staff or clearinghouse to help avoid duplicate submissions of home health and hospice claims and home health RAPs.

FOR PART A PROVIDERS

Hospital Price Transparency

The Centers for Medicare & Medicaid Services (CMS) issued the Hospital Price Transparency Final Rule in November 2019. Hospital price transparency helps Americans know the cost of a hospital item or service before receiving it. Starting January 1, 2021, each hospital operating in the United States will be required to provide clear, accessible pricing information online about the items and services they provide in two ways: (1) a comprehensive machine-readable file with all items and services, and (2) a display of shoppable services in a consumer-friendly format.

Please refer to the following CMS resources as well as the CMS Hospital Price Transparency Web page at https://www.cms.gov/hospital-price-transparency for additional guidance related to the final rule.

- December 3, 2019 Hospital Price Transparency Final Rule Call - https://www.cms.gov/outreach-and-educationoutreachnpcnational-provider-calls-and-events/2019-12-03

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- Hospital Price Transparency Frequently Asked Questions (FAQs) - https://www.cms.gov/files/document/hospital-price-transparency-frequently-asked-questions.pdf
- 8 Steps to a Machine-Readable File of All Items & Services - https://www.cms.gov/files/document/steps-machine-readable-file.pdf
- 10 Steps to Making Public Standard Charges for Shoppable Services - https://www.cms.gov/files/document/steps-making-public-standard-charges-shoppable-services.pdf
- Hospital Price Transparency Requirements Quick Reference Checklist - https://www.cms.gov/files/document/hospital-price-transparency-final-rule-quick-reference-checklists.pdf
- November 27, 2019, Federal Register - https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf
- Fact Sheet - https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price

FOR PART A PROVIDERS

MM11729 (Revised): Change to the Payment of Allogeneic Stem Cell Acquisition Services

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: MM11729 Revised
Related CR Release Date: October 20, 2020
Related CR Transmittal Number: R10402CP
Implementation Date: January 4, 2021

Related Change Request (CR) Number: 11729
Effective Date: For cost reporting periods beginning on or after October 1, 2020

Note: We revised this article to reflect the revised CR 11729 issued on October 20, 2020. The CR revision did not impact the substance of the article. In the article, we revised the CR release date, transmittal number, and the Web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for hospitals who bill Medicare Administrative Contractors (MACs) for inpatient hospital Allogeneic Stem Cell Acquisition services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

CR 11729 provides instructions to pay inpatient hospital Allogeneic Stem Cell Acquisition services on a reasonable cost basis. Please make sure your billing staffs are aware of these changes.

The complete MM11729 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/MM11729.pdf.

If you have questions, contact the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

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FOR PART B PROVIDERS

MM11954: Update to Chapter 10 of Publication (Pub.) 100-08 -Enrollment Policies for Home Infusion Therapy (HIT) Suppliers

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: MM11954
Related CR Release Date: October 30, 2020
Related CR Transmittal Number: R10434PI
Related Change Request (CR) Number: 11954
Effective Date: January 1, 2021
Implementation Date: November 1, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is for entities seeking to become Medicare suppliers that offer Home Infusion Therapy (HIT) services in coordination with the furnishing of home infusion drugs administered through an item of Durable Medical Equipment (DME) beginning in Calendar Year (CY) 2021 and in subsequent years.

PROVIDER ACTION NEEDED

CR 11954 informs Medicare Administrative Contractors (MACs) of the policies and procedures for enrolling HIT suppliers in Medicare. MACs will accept enrollment applications from HIT suppliers beginning on or after November 1, 2020. Payments will begin for dates of service on or after January 1, 2021. Please make sure your billing staffs are aware of these policies.

The complete MM11954 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/MM11954.pdf.

If you have questions, contact the CGS Provider Contact Center at **1.866.276.9558** and choose Option 1.

FOR PART B PROVIDERS

MM11982 (Revised): New Waived Tests

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: MM11982 Revised
Related CR Release Date: October 15, 2020
Related CR Transmittal Number: R10397CP
Related Change Request (CR) Number: 11982
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

Note: We revised this article to reflect a revised CR 11982, issued on October 15, 2020. The CR revised an incorrect date for one of the codes for 87804QW. The date in the article was correct already. In the article, we revised the CR release date, transmittal number, and the Web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article tells you of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS)

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must notify the MACs of the new tests so that they can accurately process claims. There are five newly added waived complexity tests listed in the table below.

The complete MM11982 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/MM11982.pdf.

If you have questions, contact the CGS Provider Contact Center at **1.866.276.9558** and choose Option 1.

FOR HOME HEALTH PROVIDERS

Friendly Reminder: Reason Code 37253

For home health claims with From dates on or after January 1, 2020, matching your claim with the Outcome and Assessment Information Set (OASIS) is more important than ever. Reason code 37253 (no OASIS found) continues to be one of the top errors for home health providers.

In most cases, the claim and OASIS is not matching because the Medicare Beneficiary Identifier (MBI) doesn't match, or the OASIS was not transmitted to Quality Improvement and Evaluation System (iQIES). Review the following Quick Tips to avoid your claims from going to the Return to Provider (RTP) file (status/location T B9997) with reason 37253. In addition, for more details, refer to the Reason Code Search and Resolution: Reason Code 37253 Web page at https://www.cgsmedicare.com/medicare_dynamic/j15/j15hhh_reasoncodes/j15hhh_reasoncodes.aspx?37253.

QUICK TIPS

- Review the OASIS FVR Report to ensure the OASIS assessment was successfully accepted.
- Check the FVR to confirm the receipt date shows the OASIS was accepted by iQIES before you submitted your claim.
- Check the Reason for Assessment (RFA) (OASIS Item M0100). It must be equal to 01, 03, 04, or 05.
- Check the occurrence code 50 and ensure that you are reporting the assessment completion date (Item M0090).
- Check the claim you submitted with the OASIS to ensure the following items match.
  - CMS Certification Number (OASIS Item M0010)
  - Medicare Beneficiary Identifier (MBI) (OASIS Item M0063)
  - Assessment Completion Date (OASIS Item M0090)
- Check the iQIES Website for known issues affecting the OASIS

If you find that the claim and OASIS have correct and matching information, contact the Provider Contact Center (PCC) at **1.877.299.4500** (Option 1).

RESOURCES

- Quick Reference Guide to OASIS Submissions and Final Validation Reports at https://qtso.cms.gov/reference-and-manuals/quick-reference-guide-oasis-submissions-and-final-validation-reports
- SE20010 MLN Matters article, Ensure Required Patient Assessment Information for Home Health Claims at https://www.cms.gov/files/document/se20010.pdf

Please share this with your appropriate staff.

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Home Health Ordering/Referring Requirements

This article serves as a reminder for home health providers about the ordering/referring billing requirements. Please share this information with your appropriate staff.

Home health services must be ordered or referred by a Doctor of Medicine (MD), Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM). The physician who orders/refers a patient for home health care must be enrolled in the Medicare program, and have an enrollment record in the Provider Enrollment, Chain, and Ownership System (PECOS).

Note: Section 3708 of the CARES Act allows a nurse practitioner, clinical nurse specialist, or physician assistant who is working in accordance with State law to order or refer home health services. This applies to claims with a claim through date on or after March 1, 2020.

To ensure this requirement is met, the Fiscal Intermediary Standard System (FISS) edits home health claims to verify the attending physician's and referring physician's National Provider Identifier (NPI) is valid and that the attending physician and referring physician is enrolled in Medicare and is in the PECOS file. Providers enter the ordering/referring physician's NPI and name on FISS Claim Page 03 as shown below.

FISS CLAIM PAGE 03

ATT PHYS	NPI ##########	L LNAME	F FNAME	M	SC
OPR PHYS	NPI	L	F	M	SC
OTH OPR	NPI	L	F	M	SC
REN PHYS	NPI	L	F	M	SC
REF PHYS	**NPI ##########**	**L LNAME**	**F FNAME**	**M**	**SC**

Before submitting your claims, follow the steps below to help avoid denial of your home health claims.

Step 1: Access the Order and Referring dataset file at https://data.cms.gov/Medicare-Enrollment/Order-and-Referring/qcn7-gc3g to verify the physician's NPI, last name, and first name. Select "View Data" and search by name or NPI. This file does not include the physician's specialty code. To verify the specialty code, refer to Step 2.

Ordering and Referring Example: If the Order and Referring dataset file shows the physician's name as Willy Wonka, enter the last name as "Wonka" in the "L" field and the first name as "Willy" in the "F" field. FISS will only verify the first initial of the first name. In this example, the first initial was entered as "W." in the "F" field. Since the period was entered after the first initial, the claim was denied because it did not match the Order and Referring dataset file.

ATT PHYS	NPI 1231231231	L WONKA	F W.	M	SC
OPR PHYS	NPI	L	F	M	SC
OTH OPR	NPI	L	F	M	SC
REN PHYS	NPI	L	F	M	SC
REF PHYS	NPI	L	F	M	SC

Things to Note:

- The NPI for the ordering/referring physician must be for an **individual physician, not a group or organizational NPI.**
- In addition, middle names (initials) and suffixes (such as MD, RPNA, etc.) should not be listed in the ordering/referring fields.
- The Order and Referring dataset file is updated weekly.

Step 2: Access the NPPES Website at https://npiregistry.cms.hhs.gov/ and search the NPI record by using the NPI, first or last name. The results will display showing the NPI, Name,

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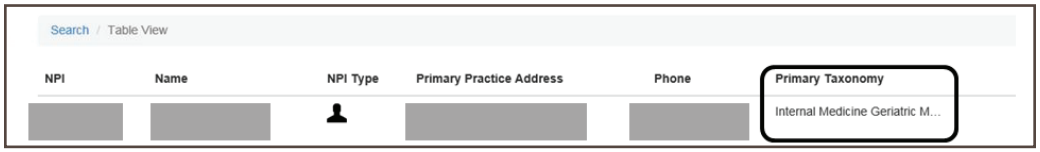
NPI Type, Primary Practice Address, Phone, and Primary Taxonomy (see below example). To determine if the physician's specialty is a valid home health ordering/referring specialty, review the information under the "Primary Taxonomy" field. In the example shown below the Primary Taxonomy field is Internal Medicine. By reviewing the Ordering/Referring Physician Checklist for Home Health Agencies quick reference tool at https://www.cgsmedicare.com/hhh/education/materials/pdf/ord_ref_phys_checklist_hha.pdf, which includes a list of specialty codes, Internal Medicine (11), indicates that this physician is a valid home health ordering/referring physician. Click on the NPI number to access additional information.

NPPES Example:



Step 3: Prior to submitting your claim, follow Steps 1 and 2, and enter the following information on FISS Claim Page 03, ensuring that it matches exactly as shown on the Order and Referring dataset.

- The NPI of the physician
- The first four letters of the physician's last name
- The physician's first name or the first letter of the physician's first name

DENIAL REASON CODES

If the above information is not entered exactly as shown on the Order and Referring dataset, your home health claim will deny with reason code 37236 (claim), or 37237 (adjustments) when:

- The attending physician NPI on the claim is not found in the eligible attending physician file from PECOS; or
- The attending physician NPI on the claim is found in the eligible attending physician file from PECOS but the name on the claim does not match the name in the PECOS file; or
- The specialty code is not a valid eligible code (see below for a list of valid home health ordering/referring specialty codes).

If the PECOS physician file includes a termination date that falls within the dates of service on the claim, the claim will deny with reason code 32072.

Note: There may be times when a physician has an enrollment record in PECOS, but they are not located on the ordering/referring data file. This is often due to the physician not completing the necessary information in PECOS which allows them to be included in the ordering/referring data file. You may need to contact the physician and ask that they complete the necessary information in PECOS.

REQUESTING A REOPENING

If your claim denies with one of the above reason codes, you may appeal the decision by submitting an Ordering/Referring Denial Reopening. Complete the Medicare HHH Reopenings Adjustment Request Form at https://www.cgsmedicare.com/hhh/appeals/pdf/hhh_reopening_form.pdf along with a hardcopy UB-04 claim form the Type of Bill (XX7), appropriate condition code, Document control Number (DCN) and an explanation in the REMARKS field. Refer to the Ordering/Referring Denial Reopenings information located on the Reopenings Web page at https://www.cgsmedicare.com/hhh/appeals/Reopenings.html for additional information. **Do not** submit a first level of appeal Redetermination request.

ADDITIONAL RESOURCES

- **SE1305 – Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856) -** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf

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- **SE1413 – Certifying Physicians and the Phase 2 Ordering and Referring Denial Edits for Home Health Agencies (HHAs) -** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1413.pdf

FOR HOME HEALTH PROVIDERS

MM11855 (Revised): Penalty for Delayed Request for Anticipated Payment (RAP) Submission – Implementation

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: MM11855 Revised
Related CR Release Date: October 27, 2020
Related CR Transmittal Number: R10403CP

Related Change Request (CR) Number: 11855
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

Note: We revised this article to reflect the revised CR 11855 issued on October 27, 2020. The CR revision added remittance advice message information and we added that information to the article. We also changed the CR release date, transmittal number, and the Web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article informs you about the implementation of the Calendar Year (CY) 2021 Home Health (HH) Request for Anticipated Payment (RAP) payment policies. Please be sure your billing staffs are aware of these changes.

The complete MM11855 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/MM11855.pdf.

If you have questions, contact the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

FOR HOSPICE PROVIDERS

CR12026: Internet Only Manual Update, Pub, 100-04, Chapter 11 – This CR Rescinds and Fully Replaces CR 11807

The Centers for Medicare & Medicaid Services (CMS) issued the Change Request 12026, Transmittal 10407 on October 30, 2020. Transmittal 10407 was then rescinded and replaced by Transmittal 10453. This CR and others can be found on the CMS Website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.

CR Release Date: October 30, 2020
CR Transmittal Number: R10407CP

Effective Date: September 7, 2020
Implementation Date: December 1, 2020

SUMMARY OF CHANGES

This Change Request (CR) makes updates to the manual language regarding submitting Notice of Termination/Revocation, Processing Professional Claims for Hospice Beneficiaries, and section about the Data Required on the Institutional Claims in Chapter 11, Sections 20.1.2, 30.3, and 40.2 of the Medicare Claims Processing Manual.

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The complete CR 10407 can be accessed at https://www.cms.gov/files/document/r10407cp.pdf. The CR 10453 can be accessed at https://www.cms.gov/files/document/r10453cp.pdf.

If you have questions, contact the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

FOR HOSPICE PROVIDERS

MM11876 (Revised): Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2021

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: MM11876 Revised
Related CR Release Date: September 24, 2020
Related CR Transmittal Number: R10372CP
Related Change Request (CR) Number: 11876
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

Note: We revised the article to reflect a revised CR 11876. The CR changed the hourly Continuous Home Care rates in the hospice tables and we made those changes to the article. We also changed the CR release date, transmittal number, and the Web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for hospice providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs, for hospice services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11876 updates the hospice payment rates, hospice wage index, and Pricer for Fiscal Year (FY) 2021. CR 11876 also updates the FY 2021 hospice aggregate cap amount. Make sure your billing staffs are aware of these changes.

The complete MM11876 *Medicare Learning Network® (MLN) Matters* article can be accessed at https://www.cms.gov/files/document/MM11876.pdf.

If you have questions, contact the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

FOR HOSPICE PROVIDERS

New Hospice Election Requirements

The fiscal year 2021 Hospice Final Rule (CMS-1733-F) at https://www.govinfo.gov/content/pkg/FR-2020-08-04/pdf/2020-16991.pdf included new hospice election statement and the hospice election statement addendum requirements. **The new requirements for the election statement and addendum are effective for all hospice elections beginning on or after October 1, 2020.**

As a result, CGS has updated the Hospice Election Requirements Web page at https://www.cgsmedicare.com/hhh/coverage/coverage_guidelines/election_requirements.html to include the following new requirements that must be included in the hospice election statement.

- Information about the holistic, comprehensive nature of the Medicare hospice benefit;
- A statement that, although it would be rare, there could be some necessary items or services that will not be covered by the hospice because the hospice has determined that

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these items or services are to treat a condition that is unrelated to the terminal illness and related conditions.

- The statement would also include information about possible beneficiary cost-sharing for hospice services.
- Notification of the beneficiary's (or representative's) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that expedited advocacy is available through the Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO) review if the beneficiary (or representative) disagrees with the hospice's determination.

As a reminder, hospices may develop their own Hospice election statements and certifications of terminal illness. Please review the following model examples for specific requirements that must be included for valid documentation.

- **Model Example of Hospice Election Statement -** https://www.cms.gov/files/document/model-hospice-election-statement-modified-july-2020.pdf
- **Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" -** https://www.cms.gov/files/document/model-hospice-election-statement-addendum-modified-july-2020.pdf

Please share this information with your appropriate staff.

TEST YOUR KNOWLEDGE AND EARN CREDIT!

https://www.surveymonkey.com/r/Dec2020Bulletin

Do you need to earn education credit? Launch the "Test your Knowledge" exercise! Correctly answer eight of ten questions based on this month's Medicare Bulletin to earn a certificate that may be used to obtain education credit through coding and/or specialty societies. Good luck!

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