CMS Quarterly Provider Updates

October 28, 2021

Today's Presenters

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Objectives

- Prepare Medicare providers to adapt to changes CMS implemented between 7/7/2021 and 10/4/2021

Agenda

- Background
  - Utilizing resources
- CRs and Related Resources
  - (Also Refer to Handout)
- Questions and Answers


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Press Release: CMS Launches New Medicare.gov Tool to Compare Nursing Home Vaccination Rates
Press Release: Biden-Harris Administration Awards $15 Million to 20 States for Mobile Crisis Intervention
Press Release: CMS Extends Open Enrollment Period and Launches Initiatives to Expand Health Coverage Access Nationwide
Fact Sheet: Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Final Rule


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2021-10-04
12453
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Change Requests

CR 11743

- Implementation of the Hospital Outpatient Department (HOPD) Prior Authorization (PA) Paired Items for the X12 278 PA Transactions
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- Supports currently implemented HOPD services based PA requests

CR 12088

- Update the International Classification of Diseases, Tenth Revision (ICD-10) 2022 Tables in the Common Working File (CWF) for Purposes of Processing Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Records and Claims
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- Instructs maintainer to upload and implement ICD-10 tables in CWF for NGHP MSP claims

CR 12177

- National Coverage Determination (NCD 110.24): Chimeric Antigen Receptor (CAR) T-cell Therapy
  - Implemented: 7/23/2021
  - Effective: 8/7/2019
- Covers autologous treatment for cancer with T-cells expressing at least one CAR when administered at healthcare facilities:
  - Enrolled in the FDA Risk Evaluation and Mitigation Strategies (REMS)
  - Meets specified CMS/FDA criteria

CR 12177

- ICD-10-PCS procedure codes for CAR T-cell therapy coverage for inpatient claims
  - XW033C3: introduction of engineered autologous chimeric antigen receptor T-cell immunotherapy into peripheral vein, percutaneous approach, new technology group 3
  - XW043C3: … into central vein, …
  - XW23346: transfusion of brexucabtagene autoleucel immunotherapy into peripheral vein, percutaneous approach, new technology group 6
  - XW24346: … into central vein, …
  - XW23376: transfusion of lisocabtagene maraleucel immunotherapy into peripheral vein, percutaneous approach, new technology group 6
  - XW24376: … into central vein…

CR 12177

- Billing for CAR T-cell therapy services
  - Inpatient TOB: 11X
  - Outpatient TOB: 12X, 13X, 85X
  - CPT codes: 0537T, 0538T, 0539T
- Revenue codes (inpatient and outpatient):
  - 0871 – cell collection with CPT code 0537T
  - 0872 – specialized biologic processing and storage – prior to transport with CPT 0538T
  - 0873 – storage and processing after receipt of cells from manufacturer with CPT 0539T
  - 0874 – infusion of modified cells with CPT 0540T
  - 0891 – special processed drugs – FDA-approved cell therapy with HCPCS Q2041, Q2042, C9073 (replaced with Q2053 April 1, 2021), or C9399

CR 12177

- HCPCS codes for billing outpatient CAR T-cell therapy
  - Q2042 for Tisagenlecleucel
  - Q2041 for Axicabtagene Ciloleucel
  - Q2053 for Brexucabtagene Autoleucel (effective 4/1/2021)
  - C9073 for Brexucabtagene Autoleucel (prior to 4/1/2021)
  - C9076 for Lisocabtagene maraleucel (effective 7/1/2021)
  - C9399 for unclassified drugs or biologicals when dose of CAR T-cell therapy exceeds code descriptor
  - 0537T for collection/handling
  - 0538T for preparation for transport
  - 0539T for receipt and preparation
  - 0540T for administration

CR 12177

- Modifier for billing CAR T-cell therapy
  - KX – indicates service performed in FDA REM approved facility

CR 12227

- Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) – Implementation
  - Implemented: 10/4/2021
  - Effective: 1/1/2022
- Implements submission of one-time home health Notice of Admission
  - Replaces submission of Requests for Anticipated Payment for every home health period of care

CR 12230

- Waiver of Coinsurance and Deductible for Hepatitis B Preventive Service Vaccine Code, Section 4104 of the Patient Protection and Affordable Health Care Act (the Affordable Care Act), Removal of Barriers to Preventive Services in Medicare
  - Implemented: 10/4/2021
  - Effective: 4/1/2018
- Waives coinsurance/copayment/deductible for Hepatitis B vaccine (HCPCS code 90739)

CR 12230

- Applies to following TOBs
  - 012X
  - 013X
  - 022X
  - 023X
  - 034X

CR 12245

- October 2021 Healthcare Common Procedure Coding System (HCPCS) Quarterly Update Reminder
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- Updates HCPCS code file

CR 12272

- October Quarterly Update to 2021 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- Additional information on institutional and professional billing under SNF CB: SNF Consolidated Billing

CR 12272

- Added to list of statutory exclusions from SNF CB:
  - Certain blood clotting factors indicated for treatment of hemophilia and other bleeding disorders effective for claims with DOS on/after 10/1/2021
    - J7170, J7175, J7179, J7180–J7183, J7185–J7205, J7207, J7209–J7212
  - One chemotherapy code effective for claims with DOS on/after 7/1/2021
    - Q5123

CR 12279

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) – October 2021
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- CR 12297 NCD spreadsheet
- List of previous NCD Coding Updates

CR 12279

- NCDs with ICD-10 updates include
  - NCD 30.3.3 Acupuncture for Chronic Low-Back Pain
    - See also MLN Matters article MM11755
  - NCD 20.33 Transcatheter Mitral Valve Repair/Transcatheter Edge-to-Edge Repair (TMVR/TEER)

CR 12280

- National Coverage Determination (NCD) 210.3 - Screening for Colorectal Cancer (CRC) - Blood-Based Biomarker Tests
  - Implemented: 10/4/2021
  - Effective: 1/19/2021
- Blood-based biomarker test is appropriate CRC screening test
  - Must be ordered by a treating physician
  - Allowed once every three years when performed in Clinical Laboratory Improvement Act (CLIA)-certified laboratory

CR 12280

- Additional requirements
  - Patient
    - Asymptomatic
    - Average risk of developing CRC
  - Blood-based biomarker screening test must have:
    - FDA market authorization with indication for CRC screening
    - Proven test performance characteristics for blood-based screening test with both sensitivity greater than or equal to 74% and specificity greater than or equal to 90% in detection of CRC compared to recognized standard (accepted as colonoscopy at this time)

CR 12280

- HCPCS code G0327 – Colorectal cancer screening; blood-based biomarker
- One of the following ICD-10 codes
  - Z12.11 Encounter for screening for malignant neoplasm of colon
  - Z12.12 Encounter for screening for malignant neoplasm of rectum
- Not subject to Medicare deductible or coinsurance
- Next eligible date is being added to CWF

CR 12290

- National Coverage Determination (NCD) 20.9.1 Ventricular Assist Devices (VADs)
  - Implemented: 7/27/2021
  - Effective: 12/1/2020
- Revises relevant sections of CMS IOM
  - 100-03, Medicare National Coverage Determinations (NCD Manual, Chapter 1, Part 1, Section 20.9
  - 100-04, *Medicare Claims Processing Manual*, Chapter 32, Section 320

CR 12290

- Medicare covers FDA approved left ventricular assist device (LVAD) for short or long term mechanical circulatory support for heart failure patients meeting following criteria
  - Have New York Heart Association (NYHA) Class IV heart failure; and
  - Have a left ventricular ejection fraction (LVEF) ≤ 25%; and
  - Are inotrope dependent
    - OR

CR 12290

- Have Cardiac Index (CI) < 2.2 L/min/m^2 while not on inotropes and meet one of the following
  - Are on optimal medical management (OMM), based on current heart failure practice guidelines for at least 45 out of last 60 days and are failing to respond
  - Have advanced heart failure for at least 14 days and are dependent on intra-aortic balloon pump (IABP) or similar temporary mechanical circulatory support for at least seven days
- Medical team
  - Explicitly identified, cohesive, multidisciplinary team of medical professionals with appropriate qualifications, training, and experience must manage patients receiving VAD

CR 12290

- Must ensure patients and caregivers have knowledge and support necessary to participate in informed decision making
- Must be based at facility and must include individuals with experience working with patients before and after placement of VAD

- Team members must include, at a minimum
  - At least one physician with cardiothoracic surgery privileges and individual experience implanting at least 10 durable, intracorporeal, LVADs over course of previous 36 months with activity in last year

CR 12290

- At least one cardiologist trained in advanced heart failure with clinical competence in medical-based and device-based management, including VADs, and clinical competence in management of patients before and after placement of VAD
- VAD program coordinator
- Social worker
- Palliative care specialist

- Additional information: VAD Destination Therapy Facilities

CR 12307

- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- Hereditary hemolytic and sickle cell anemia chronic comorbidity category
  - Adds additional diagnosis codes
    - D55.21 Anemia due to pyruvate kinase deficiency
    - D55.29 Anemia due to other disorders of glycolytic enzymes

CR 12307

- Removes diagnosis codes/not eligible for co-morbidity payment adjustment
  - D55.2 Anemia due to disorders of glycolytic enzymes
- Additional information on ESRD PPS Patient-level Adjustments

CR 12342

- October 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- CMS provides ASP Drug Pricing Files, including ASP and Not Otherwise Classified (NOC) drugs, for Medicare Part B drugs on quarterly basis
  - Payment allowance limits provided for OPPS/OCE via separate instructions

CR 12364

- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2022
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- FY 2022 rates:
  - Standard Federal rate = $17,240; Adjusted standard Federal rate = $16,901

CR 12364

- Fixed loss amount = $9,491
- Labor-related share = 0.729; Non-labor-related share = 0.271
- Urban national average Cost-to-Charge Ratio (CCR) = 0.394; Rural national average CCR = 0.478
- Low Income Patient (LIP) Adjustment = 0.3177; Teaching adjustment = 1.0163
- Rural adjustment = 1.149

CR 12366

- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2022
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- Additional information: CMS SNF PPS

CR 12384

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2021
  - Implemented: 10/4/2021
  - Effective: 10/1/2021 (Unless noted differently in requirements)
- NCD spreadsheet for CR 12384
  - NCDs impacted: 190.12; 190.14-190.18; 190.20A; 190.20B; 190.28; 190.32-190.34

CR 12408

- Notice of New Interest Rate for Medicare Overpayments and Underpayments - 4th Qtr Notification for FY 2021
  - Implemented: 7/19/2021
  - Effective: 7/19/2021
- Interest rate of 9.625 percent, effective 7/19/2021, for Medicare overpayments and underpayments

CR 12417

- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2022
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- Discharges occurring 10/1/2021-9/30/2022
  - IPF PPS Federal per diem base rate for FY 2022 = $832.94
  - Adjusted market basket update = 2.0 percent
  - Wage index budget neutrality factor = 1.0017
  - ECT payment per treatment = $358.60

CR 12417

- Fixed dollar loss threshold = $16,040.00
- IPFs designated as rural continue to receive 17% rural adjustment

- IPF not sending quality data under IPFQR Program for FY 2022 are reduced by 2%
  - IPF PPS Federal per diem base rate for FY 2022 = $816.61
  - ECT payment per treatment = $351.57
- FY 2022 ICD-10-CM and ICD-10 PCS Updates
- FY 2022 IPF PPS Comorbidity Categories and additional FY2022 IPF PPS files

CR 12421

- Influenza Vaccine Payment Allowances - Annual Update for 2021-2022 Season
  - Implemented: 10/1/2021
  - Effective: 8/1/2021
- Medicare Part B payment allowance limits for flu shots are 95% of Average Wholesale Price (AWP); except where paid under reasonable cost:
  - Hospital outpatient department
  - Rural Health Clinic (RHC)
  - Federally Qualified Health Center (FQHC)

CR 12421

- Seasonal Influenza Vaccines Pricing
- Note
  - 2021–2022 season began on 8/1/2021 and NGS/MACs should complete reprocessing of any impacted claims by 11/1/2021
  - NGS/MAC will decide Medicare Part B payment allowance for HCPCS code Q2039 provided on DOS 8/1/2021–7/31/2022

CR 12422

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2021 Update
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- CPT code
  - 31591 – effective DOS on/after 1/1/2021 bilateral indicator = 1
  - 0648T, 0648T-TC, 0648T-26 – effective DOS on/after 7/1/2021 diagnostic imaging family indicator = 88

CR 12422

- Procedure Status Indicator = X
  - Effective DOS on/after 5/26/2021: M0247; M0248; Q0247
  - Effective DOS on/after 6/3/2021: Q0244
  - Effective DOS on/after 6/8/2021: M0201
  - Effective DOS on/after 6/24/2021: M0249; M0250; Q0249
- Deleted from MPFS effective DOS on/after 10/1/2021
  - J0693; J7303; J9315; Q4228; Q4236

CR 12422

- New codes effective DOS on/after 10/1/2021
  - A4453; J0699; J0741; J1305; J1426; J1445; J1448; J2406; J7294; J7295; J9247; J9318; J9319; P9025; P9026; Q2054; Q4251; Q4252; Q4253; Q9004; S9432
- Additional information
  - Medicare Physician Fee Schedule Overview and Database
  - HCPCS Quarterly Update

CR 12432

- October 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.3
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- CMS Outpatient Code Editor (OCE)
- Summary of October 2021 Quarterly Release Modifications

CR 12435

- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to reasonable Charge Payment
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- New Codes effective 10/1/2021: 0255U-0274U
  - Contractor-priced (where applicable) until nationally priced and undergo CLFS annual payment determination process
- CMS Quarterly Clinical Laboratory Fee Schedule

CR 12435

- Next CLFS Data Reporting Period, 1/1/2022-3/31/2022, for Clinical Diagnostic Laboratory Tests will be based on original data collection period of 1/1/2019-6/30/2019
  - Note: three-year data reporting cycle for CDLTs that are not ADLTs (2025, 2028, etc.)
- PAMA Regulations

CR 12436

- October 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)
  - Implemented: 10/4/2021
  - Effective: 10/1/2021
- Refer to OPPS Addendum A and B for October 2021 quarterly HCPCS codes, SIs, APCs, etc.
  - Effective 10/1/2021, payment rates for many drugs and biologicals have changed and updated rates are included in OPPS Addendum A and B
- CMS 2021 Status Indicator list
  - Hospital Outpatient Regulations and Notices > 2022 > "Related Links" > "2022 NPRM (NFRM, if available) OPPS Addenda" > open excel files and select "Addendum D1"

CR 12436

- CMS COVID-19 Vaccines and Monoclonal Antibodies – Payment rate, effective dates, and more
  - Additional information on CMS Monoclonal Antibody Covid-19 Infusion
- New COVID-19 Codes
  - 0003A – Third dose of Pfizer-BioNTech vaccine – SI S; APC 9398
  - 0013A – Administration of third dose of Moderna vaccine – SI S; APC 9398

CR 12436

- New COVID-19 Codes – Administered in Patient's home
  - M0201 – additional payment for Covid-19 vaccine administered in patient's home – SI S; APC 1494
    - Can be billed with: 0001A, 0002A, 0003A, 0011A, 0012A, 0013A, or 0031A
- New COVID-19 Monoclonal Antibody Codes
  - M0247, M0248 Sotrovimab – SI S; APC: 1506 for M0247, 1509 for MM0248
  - Q0247 – Administration of Sotrovimab – SI L
  - Q0244 – Casirivimab and Imdevimab for revised EUA dosing regime – SI L

CR 12436

- M0240, M0241 – Repeat Administration of Casirivimab and Imdevimab – SI S; APC 1506 for M0240 and 1509 for M0241
- Q0240 – New dosing for Casirivimab and Imdevimab – SI L

- New COVID-19 Monoclonal Antibody Codes
  - M0243 – Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection
  - M0244 – Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection - home

CR 12436

- M0249 – tocilizumab, first dose; SI S; APC 1506
- M0250 – tocilizumab, second dose; SI S; APC 1506
- Q0249 – tocilizumab , 1 mg; SI L

- Proprietary Laboratory Analyses (PLA) Coding Changes
  - Deleted 0139U and 0168U
  - Revised 0051U
  - 30 new PLA codes: CPT codes 0255U through 0284U
- New Multianalyte Assays with Algorithmic Analyses (MAAA): CPT code 0018M; SI Q4

CR 12436

- New code C9779 – endoscopy or colonoscopy, mucosal closure, when performed; SI J1; APC 5313
- CPT code C9780 – insertion of CV catheter through central venous occlusion via inferior and superior approaches (e.g., inside-out technique), including imaging guidance; SI S, APC 1534
- New device pass-through code as of 10/1/2021:
  - C1716 (Catheter, transluminal intravascular lithotripsy, coronary)

CR 12436

- Always bill device(s) in category described by HCPCS code
  - C1831 with one of primary CPT codes: 22558, 22586, 22612, 22630, or 22633 and add-on code 22853 or 22854
  - C1761 with either C9600, 92928 or, effective 7/1/2021: 92933, 92943, C9602, or C9607
    - APC 5193 when C1761 billed with: 92943, 92928, or C9600
    - APC 5194 when C1761 billed with: 92933, C9602, or C9607
- Skin Substitute Products
  - New – Low Cost: Q4251, Q4252, Q4253
  - Deleted: Q4228, Q4236

CR 12436

- Change to SI for Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
  - CPT code 90677 – changed to SI L
- New Blood Product HCPCS Codes
  - P9025: Plasma, cryoprecipitate reduced, pathogen reduced, each unit; SI R; APC 9538
  - P9026: Cryoprecipitated fibrinogen complex, pathogen reduced, each unit; SI R; APC 9539
- Refer to various tables CR 12436 for additional coding updates

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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