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Part A FY 2023 Q1 CMS Quarterly Update

2/14/2023

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objectives

- Prepare Medicare providers to adapt to changes CMS implemented between **10/5/2022 and 1/4/2023** (unless otherwise noted)

Agenda

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

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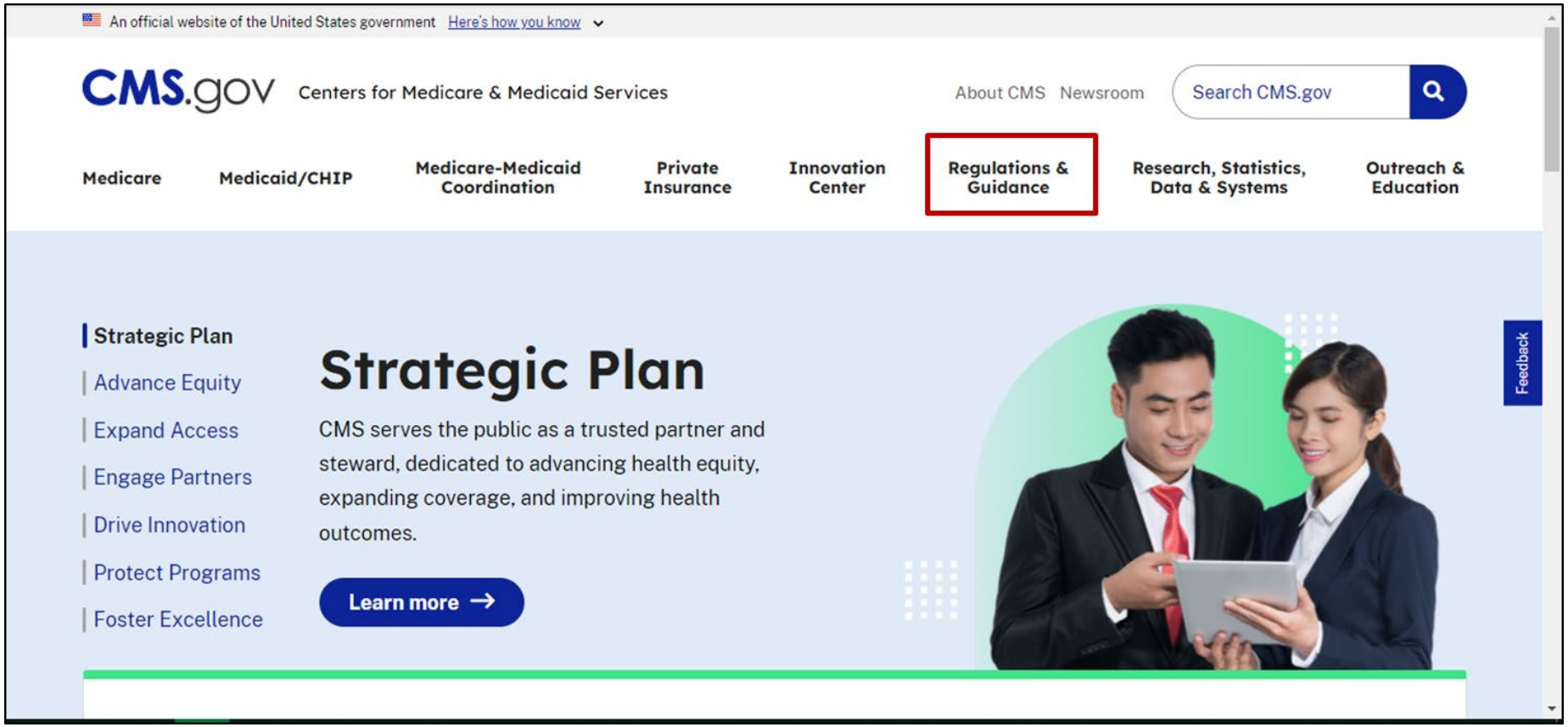
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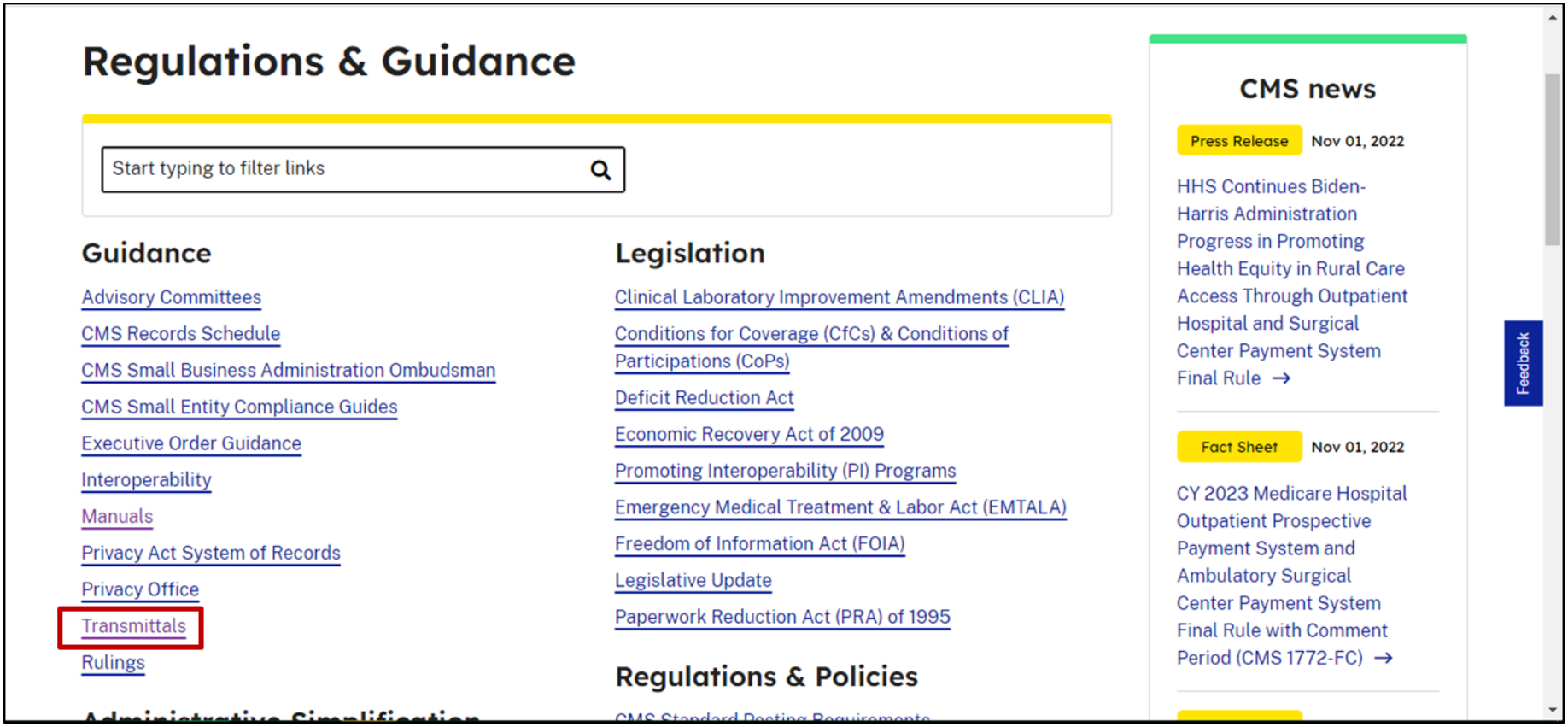
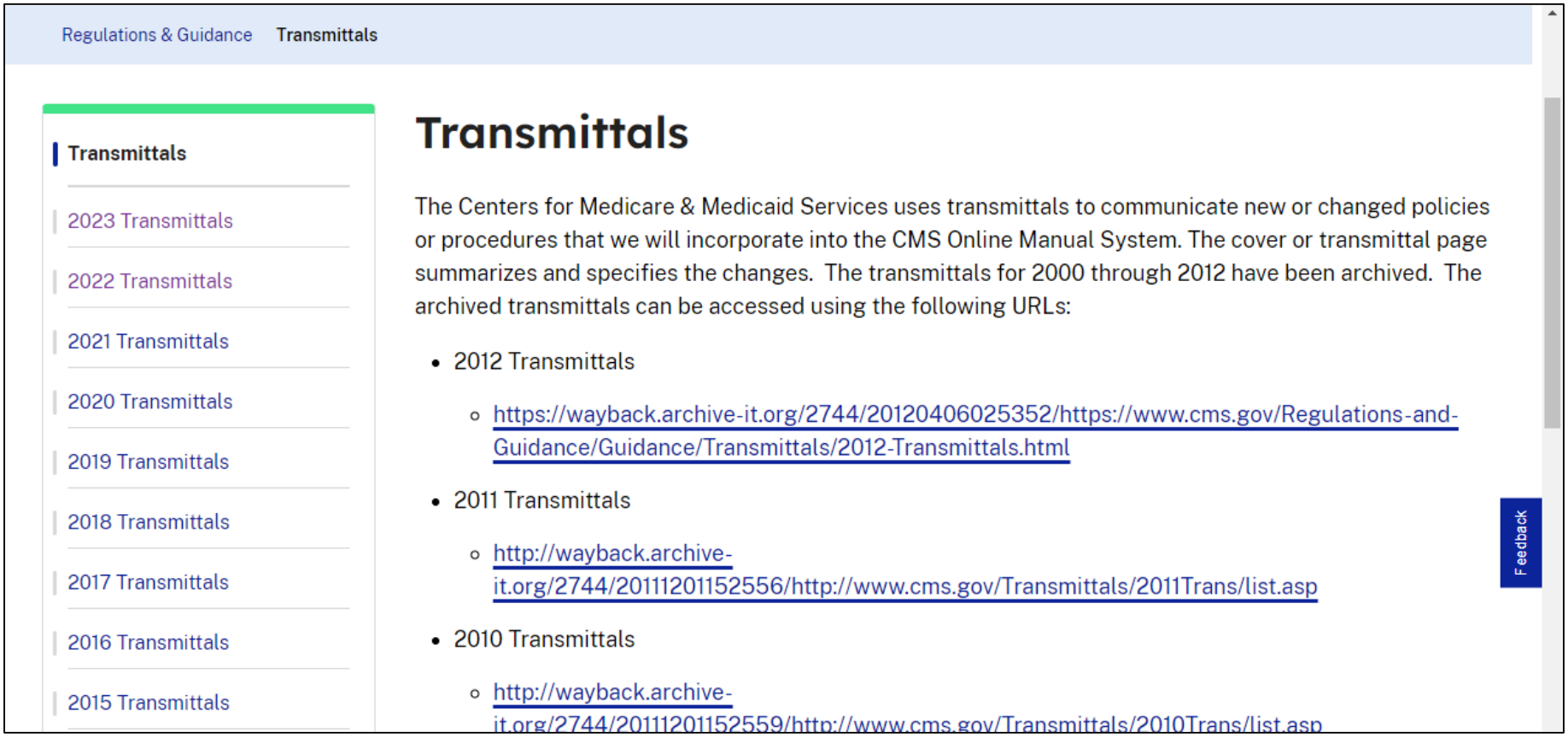
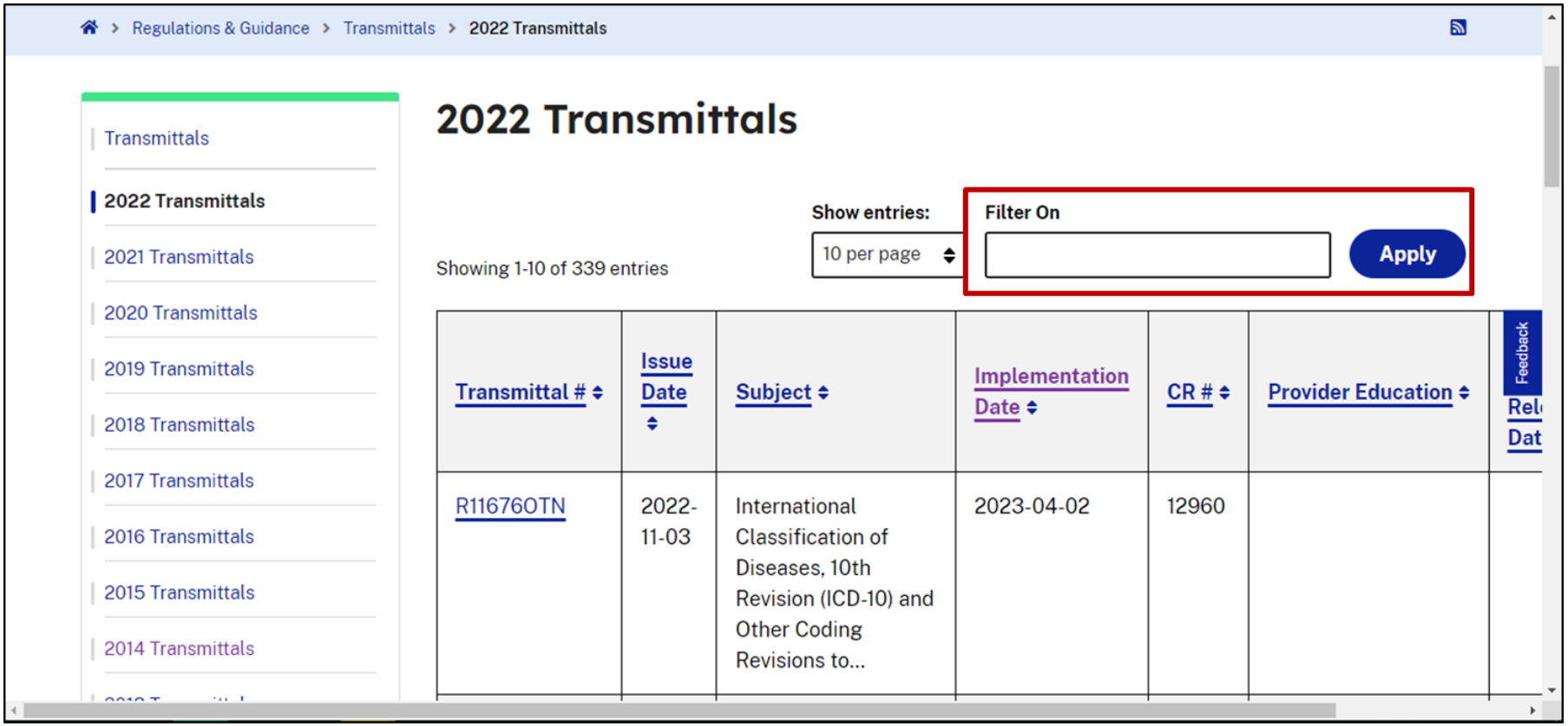


Transmittals Page



2022 Transmittals Page



Transmittals/Change Requests

10/5/2022-1/4/2023

CR 12347

- Implementation of the CRA for the TPNIES Under the ESRD PPS
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2022

CR 12347

- Offset adjustment amount updated by ESRD market basket percentage increase minus productivity adjustment factor
  - Expected number of treatments remains 156/year
- Report HCPCS code on TPNIES CRA list with modifier AX and one of following revenue codes
  - 0823 – hemodialysis home equipment
  - 0833 – peritoneal home equipment

CR 12347

- 0843 –CAPD home equipment
- 0853 –CCPD home equipment
- 0889 – other miscellaneous dialysis (ultrafiltration home equipment)

- Does not apply to per-treatment amount paid to ESRDs providing dialysis for AKI patients

CR 12656

- Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter As Certain Colorectal Cancer Screening Tests
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2022
- CMS will gradually reduce coinsurance for procedures

CR 12656

- Applies to procedures performed
  - In connection with colorectal cancer screening
  - As result of screening
  - In same clinical encounter as screening
- Report modifier PT on claim line with HCPCS/CPT codes 10000-69999, G0500, 00811, or 99156
  - Indicates screening procedure has become diagnostic

CR 12656

- Coinsurance reduced or waived
  - CY 2023-2026, coinsurance is 15%
  - CY 2027-2029, coinsurance is 10%
  - Starting CY 2030, coinsurance waived

CR 12694

- Updated MIPS/MVP HCPCS Codes
  - Implementation date: 1/3/2023
  - Effective date: 1/3/2023
- Codes are not billable; include on claim for measurement purposes only
  - See Attachment to CR for HCPCS code list

CR 12765

- Significant Updates to CMS Internet Only Manual, Publication, 100-05 *Medicare Secondary Payer (MSP) Manual,* Chapter 5
  - Implementation date: 10/13/2022
  - Effective date: 10/13/2022
- BCRC/COBC known as MSP Contractor responsible for coordination of benefits
- Claims unrelated to MSP will be paid
  - Section 20.4.2

CR 12765

- Submitting a claim as Medicare primary indicates no other primary coverage
  - See exceptions, section 30.2
- Medicare is secondary during 30-month ESRD coordination period
  - Section 30.3.1
- Black lung claims should be sent to US DOL
  - Section 30.4

CR 12765

- CARCs used to determine why no-fault insurer did not pay, whether Medicare should pay
  - Section 30.5.2
- If GHP denies claim, note reason for denial on claim, no attachment needed
  - Sections 40.1, 40.3
    - Ex: deductible applies, patient not entitled to benefits, benefits exhausted, services not covered under plan

CR 12769

- New Edit for PPS Outpatient and Inpatient Bill Types Receiving an Outlier Payment When a Device Credit is Reported
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Implements a claim level edit for OPPS and IPPS TOBs to validate Medicare outlier overpayment

CR 12798

- Cessation of Use of MyMedicare.gov Web Address
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Replaces website with Medicare.gov

CR 12804

- New Medicare PBID - Implementation
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Allows patients whose coverage ends 36 months after successful transplant to keep Part B only for immunosuppressive drugs with no time limit

CR 12806

- 2023 Annual Update for the HPSA Bonus Payments
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- ZIP Codes designated as HPSA in 2023 that are eligible for a Medicare Physician Bonus
  - Physician Bonuses
  - Medicare Physician Bonus Payment Eligibility Analyzer

CR 12816

- Billing for Hospital Part B Inpatient Services
  - Implementation date: 10/11/2022
  - Effective date: 7/1/2022
- Report services on 12X TOB
  - When to bill Part B for inpatient services
    - CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 6, Section 10
  - Time limitations for filing Part B claims
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70

CR 12816

- Services allowed on inpatient Part B claims
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual, Chapter 4*, Section 240

CR 12820

- Implementation of REH Provider Type
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Facilities must meet regulatory requirements
  - Enroll in Medicare
  - Transfer agreement with Level I or II trauma center
  - Staffing requirements similar to CAH, physician, NP, CNS, PA available to provide services 24 hours per day

CR 12820

- Don't exceed annual per patient average of 24 hours of services
- Don't provide acute care IP hospital services
- Was CAH or small rural hospital (> 50 beds)
  - Submit CMS-855A to convert to REH
- Submit claims to Part A via 837I or CMS-1450
  - TOB 13X or 14X
- Payment for REH services is 5% over OPPS rate
  - Copayment based on standard OPPS rate, excluding 5%

CR 12820

- Additional facility payments sent in 12 monthly installments
  - CY 2023 additional monthly REH facility payment is $272,866, subject to annual increase

CR 12829

- 2023 Annual Update of HCPC Codes for SNF CB Update
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Updated HCPCS codes
- General Explanation of the Major Categories

CR 12860

- Annual Clotting Factor Furnishing Fee Update 2023
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Clotting factor furnishing fee for 2023 is $0.25 per unit
  - Blood Clotting Factor Furnishing Fee

CR 12867

- Medicare Enrollment of REHs
  - Implementation date: 10/28/2022
  - Effective date: 10/28/2022
- CAH/rural hospital with not more than 50 beds as of 12/27/2020 eligible to convert to REH
  - Must provide emergency services and observation care
  - Prohibited from providing inpatient services

CR 12867

- Medicare Enrollment
  - Submit for CMS-855A change of information application to convert to REH
    - No application fee required
- Medicare Billing
  - Submit Part A claims via 837I
  - Report TOB 13X and 14X
  - Do not bill for inpatient services
- Most REH services are a Part B benefit

CR 12867

- Medicare Reimbursement
  - Additional 5% over OPPS rate for service
    - Copayment calculations exclude 5% increase
  - Services that don't meet definition of REH service
    - Paid at same rate as service provided at OPPS hospital
    - Based on applicable fee schedule
    - Will not generate additional 5% payment
  - Ambulance fee schedule paid if REH owns and operates ambulance entity

CR 12867

- Post-hospital extended care services with distinct part licensed SNF unit will be paid based on SNF PPS
- Additional monthly REH facility payments
  - Maintain detailed reports on how payments are spent
  - CY 2023 payment rate is $272,866
    - Subject to annual increase
- CMS MLN Fact Sheet (MLN2259384) Rural Emergency Hospitals

CR 12888

- Changes to the Laboratory NCD Edit Software for January 2023
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- NCDs with coding updates
  - Urine Culture, Bacterial (190.12)
  - HIV Testing (Prognosis Including Monitoring) (190.13)

CR 12888

- Blood Counts (190.15)
- PTT (190.16)
- PT (190.17)
- Serum Iron Studies (190.18)
- Collagen Crosslinks, Any Method (190.19)
- Blood Glucose Testing (190.20A and 190.20)
- Glycated Hemoglobin/Glycated Protein (190.21)
- Thyroid Testing (190.22)
- Lipids Testing (190.23A and 190.23B)

CR 12888

- Digoxin Therapeutic Drug Assay (190.24)
- Alpha-fetoprotein (190.25)
- Carcinoembryonic Antigen (190.26)
- Human Chorionic Gonadotropin (190.27)
- Tumor Antigen by Immunoassay CA 125 (190.28)
- Tumor Antigen by Immunoassay CA 15-3/CA 27.29 (190.29)
- Tumor Antigen by Immunoassay CA 19-9 (190.30)
- Prostate Specific Antigen (190.31)

CR 12888

- Gamma Glutamyl Transferase (190.32)
- Hepatitis Panel/Acute Hepatitis Panel (190.33)
- Fecal Occult Blood Test (190.34)

- NCD spreadsheet

CR 12903

- Update to Medicare Deductible, Coinsurance and Premium Rates for CY 2023
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Part A Deductible
  - $1,600 per year

CR 12903

- Part A Coinsurance
  - $400 per day for days 61-90
  - $800 per day for days 91-150 (LTR days)
  - $200 per day for days 21-100 (SNF coinsurance)
- Part A BP
  - $506 per month

CR 12903

- Part B Standard Premium
  - $164.90 per month
- Part B Deductible
  - $226 per year
- Coinsurance
  - 20% services

CR 12908

- Quarterly Update to the NCC PTP Edits, Version 29.0, Effective 1/1/2023
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Procedure-to-Procedure Edits
- Medically Unlikely Edits
- Add-on Code Edits

CR 12923

- 2023 Annual Update of Per-Beneficiary Threshold Amounts…
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Updates annual per beneficiary KX modifier thresholds
  - Commonly referred to as "therapy caps"
    - $2,230 for PT and SLP, combined
    - $2,230 for OT

CR 12950

- NCD 200.3 - Monoclonal Antibodies Directed Against Amyloid for the Treatment of AD
  - Implementation date: 12/12/2022
  - Effective date: 4/7/2022
- Review coverage criteria

CR 12950

- Individually approved clinical trials require a new HCPCS code specific to the therapy being studied
  - Report existing HCPCS codes J3490 or J3590 to identify therapies with FDA approval that don't have an assigned and dedicated HCPCS code
- Requires ICD-10 diagnosis code Z00.6 and one of the following additional diagnosis codes:
  - G30.0, G30.1, G30.8, G30.9, G31.84

CR 12961

- Update to the FQHC PPS for CY 2023
  - Implementation date: 1/2/2023
  - Effective date: 1/1/2023
- FQHC PPS base rate is $187.19
- GAFs updated

CR 12965

- Billing for Hospital Part B Inpatient Services
  - Implementation date: 12/12/2022
  - Effective date: 7/1/2022
- Bill Part B inpatient services on 12X TOB
  - When Medicare pays (CMS IOM 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10)
  - Time limit for filing a claim (CMS IOM Publication, 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70)
  - Services allowed on claims (CMS IOM Publication 100-04, *Medicare Claims Processing Manual*,, Chapter 4, Section 240)

CR 12967

- Notice of New Interest Rate for Medicare Overpayments and Underpayments -1st Qtr Notification for FY 2023
  - Implementation date: 10/18/2022
  - Effective date: 10/18/2022
- Private consumer rate is 10.125%

CR 12973

- ICD-10 Code Update for Coverage of IVIG Treatment of Primary Immune Deficiency Diseases in the Home
  - Implementation date: 12/12/2022
  - Effective date: 10/1/2022
- Adds ICD-10-CM diagnosis code D81.82

CR 12978

- Implementation of Changes in the ESRD PPS and Payment for Dialysis Furnished for AKI in ESRD Facilities for CY 2023
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Updates CY 2023 rates, policies for ESRD PPS, renal dialysis services for patients with AKI

CR 12978

- CY 2023
  - ESRD PPS base rate is $265.57
  - AKI dialysis payment rate is $265.57
  - ESRD CB list adds
    - J1444 to anemia management effective 7/1/2019
    - J0879 to composite rate drugs and biologicals effective 4/1/2022
    - J0899 to access management effective 1/1/2023

CR 12978

- ESRD PPS Outlier services updated to show the most recent mean unit cost
  - Revised mean dispensing fee of NDCs qualifying for outlier consideration to $0.51 per NDC per month
- One eligible TDAPA drug, difelikefalin (J0879), continues for CY 2023 (from 4/1/2022 through 3/31/2021)
  - Report AX modifier with J0879 for TDAPA payment; does not qualify toward outlier calculation/payment
  - Report any discarded amount using JW modifier in second modifier position on claim

CR 12978

- One eligible CRA for TPNIES
  - Average per treatment CRA for TPNIES offset amount is $9.79
  - HCPCS code E1629 (Tablo hemodialysis system for the billable dialysis services)
    - Report with revenue code 0823 with AX modifier
    - Add to Remarks section of claim
      - HCPCS
      - Description of item
      - Billed amount to Medicare
      - Invoice amount
      - Wholesale amount per item
      - Discount or rebate amount per item (even if bulk discount)

CR 12982

- Summary of Policies in the CY 2023 MPFS Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- CY 2023 updates:

CR 12982

- HCPCS code Q3014 (Telehealth originating site facility fee) payment is 80% of lesser of actual charge, or $28.64
  - Beneficiary responsible for any unmet deductible amount and Medicare coinsurance
- New Category 1 telehealth HCPCS codes
  - G0316, G0317, G0318, G3002, and G3003
- Category 3 telehealth CPT codes–temporarily retained as "Available up Through December 31, 2023"
  - 90875, 90901, 92012, 92014, 92550, 92552, 92553, 92555 - 92557, 92563, 92567, 92568, 92570, 92587, 92588, 92601, 92625 - 92627, 94005, 95970, 95983, 95984, 96105, 96110, 96112, 96113, 96127, 96170, 96171, 97129, 97130, 97150 - 97158, 97530, 97537, 97542, 97763, 98960 - 98962, 99473, 0362T, and 0373T

CR 12982

- CMS extended the duration of time that services are temporarily included on the Medicare Telehealth Services List during the PHE, but are not included on a Category I, II, or III basis
  - 151 days following the end of the COVID-19 PHE
  - Includes allowing
    - Telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home
    - Certain services may be furnished via audio-only telecommunications systems
    - Physical therapists, occupational therapists, speech-language pathologists, and audiologists may furnish telehealth services

CR 12982

  - telehealth claims may continue to be billed with the place of service indicator of what it would have been had the service been billed for an in-person visit.
    - » Requires modifier "95" to identify them as services performed and provided as telehealth services through the later of the end of CY 2023 or end of the year in which the PHE ends
- List of Telehealth Services

- Changes for Other E/M visits
  - Merger of hospital inpatient and observation visits into a single code set, and merger of domiciliary, rest home (e.g., boarding home), or custodial care and home visits into a single code set.

CR 12982

- Choice of medical decision making or time to select visit level (except for visits that are not timed, such as emergency department visits)
- Eliminated use of history and exam to determine visit level (instead there is a requirement for a medically appropriate history and/or exam)
- New descriptor times (where relevant)
- Revised CPT E/M guidelines for levels of medical decision making

- New G codes for reporting (one per EM family) - Do not use CPT codes
  - G0316 - Prolonged hospital inpatient or observation services

CR 12982

- G0317 - Prolonged nursing facility services
- G0318 - Prolonged home or residence services
- G2212 – Prolonged cognitive impairment assessment services (which is the Medicare-specific code for prolonged office/ outpatient services)

- New HCPCS code G0323 – General Behavioral Health Integration performed by CP or CSW to account for monthly care integration where the mental health services provided by a CP or CSW are serving as the focal point of care integration.

CR 12982

- Expanded Coverage for CRC Screening and Reducing Barriers
  - Certain CRC screening tests are covered for beneficiary 45 years of age or older
    - Blood-based Biomarker Tests, The Cologuard™ – Multi-target Stool DNA (sDNA) Test, Immunoassay-based Fecal Occult Blood Test (iFOBT), Guaiac-based Fecal Occult Blood Test (gFOBT), Barium Enema Test, and Flexible Sigmoidoscopy Test. Screening
    - Coverage for colonoscopy continue with no minimum age limitation

CR 12982

- New codes for CPM
  - G3002 and G3003 - monthly CPM – by physicians and other qualified health professionals
- OTPs
  - Revises pricing methodology for drug component of methadone weekly bundle and add-on code for take-home methadone supplies
  - Modifies payment rate for individual therapy in non-drug component of the bundled payments for episodes of care
  - Allows OTP intake add-on code to initiate treatment with buprenorphine provided via 2-way audio-video communications

CR 12982

technology or audio-only technology when audio-video technology isn't available and all requirements are met

- Extends the flexibility through the end of CY 2023 to provide periodic assessments via audio-only when video isn't available, when authorized by SAMHSA and DEA
- Clarifies OTPs can bill for medically reasonable and necessary services provided via mobile units

CR 12998

- January 2023 I/OCE Specifications Version 24.0
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Provides I/OCE instructions used under OPPS and non-OPPS
  - Outpatient Code Editor (OCE)

CR 12998

- Claims processing changes effective 1/1/2023
  - Hospital outpatient departments
  - Community mental health centers
  - Non-OPPS hospital providers
  - Limited services when provided in a HH agency that isn't paid under HH PPS
  - Hospice patients for non-terminal illness treatment

CR 12999

- Update to RHC AIR Payment Limit for CY 2023
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- RHC payment limit per visit for CY 2023 is $126
  - Independent RHCs and provider-based RHCs in a hospital with 50 or more beds

CR 13023

- CY 2023 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
  - General specimen collection fee increased to $8.57
    - Specimen collection fee Increased to $10.57 for those specimens collected in a SNF or by a laboratory on behalf of a HHA
  - Clarifies and modifies Medicare CLFS travel allowance policies

CR 13031

- January 2023 Update of the Hospital OPPS
  - Implementation date: 1/3/2023
  - Effective date: 1/1/2023
- Payment system updates and new codes for
  - COVID-19
  - Drugs, biologicals, and radiopharmaceuticals
  - Devices

CR 13031

- New COVID-19 Vaccine & Administration Codes
  - Codes are effective upon receiving EUA or approval from the FDA
  - Beneficiary cost-sharing does not apply to COVID-19 vaccines
  - Attachment A
    - Table 1: Provides list and descriptors for Covid-19 Vaccine Product and Administration CPT Codes
    - Table 2: Provides COVID-19 Vaccine Administration APCs
      - Also refer to the January 2023 OPPS Addendum B

CR 13031

- 9 new PLA codes effective 1/1/2023
  - CPT codes 0355U through 0363U
- 3 new devices approved for pass-through status: HCPCS codes C1747, C1826, and C1827
- Transitional Pass-Through Payments for Designated Devices
  - Most current OPPS HCPCS Offset file is available in Addendum P of the CY 2023 OPPS/ ASC final rule

CR 13031

- Dental Coding
  - HCPCS code G0330 – describes technical facility-fee for dental rehabilitation services only
    - For procedures performed on a patient requiring monitored anesthesia and use of an operating room
  - CPT Code 41899 (APC 5161) clarification
    - May be used more broadly to describe other dental or dental-related procedures on the teeth and gums, not otherwise described by other HCPCS codes currently assigned to APCs or for covered non-surgical dental services and surgical dental services provided to patients not requiring monitored anesthesia and the use of an operating room

CR 13031

- Changes to IPO for CY 2023: Removes 11 and adds eight procedures
  - Refer to Table 8 of Attachment A
- Effective 1/1/2023, behavioral health services furnished by hospital/CAH OPD remotely via telecommunications technology to beneficiary at home are covered
  - When beneficiary receives an in-person service within six months prior to the first remote behavioral service except where there is an ongoing clinical relationship

CR 13031

- New modifier JZ
  - Effective 1/1/2023, voluntary use when no amount of drug is discarded from a single dose or single use packaging
  - Required, when applicable, beginning 7/1/2023 - Providers must report the JZ modifier for all applicable drugs with no discarded drug amounts
- 340B billing
  - Must continue to report "JG" and "TB" modifiers for informational purposes as applicable

CR 13031

- Payment adjustment amount under IPPS and OPPS for Domestic NIOSH-approved Surgical N95 Respirators
  - Provided biweekly as interim lump-sum payments to hospital and reconciled at cost report settlement for cost reporting periods beginning on or after 1/1/2023
    - Any IPPS and or OPPS provider can request biweekly interim lump sum payments for an applicable cost reporting period
    - CMS is creating a new supplemental cost reporting form

Thank You!

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

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