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# NGS CMS Quarterly Updates

4/26/2022

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

# Today's Presenters

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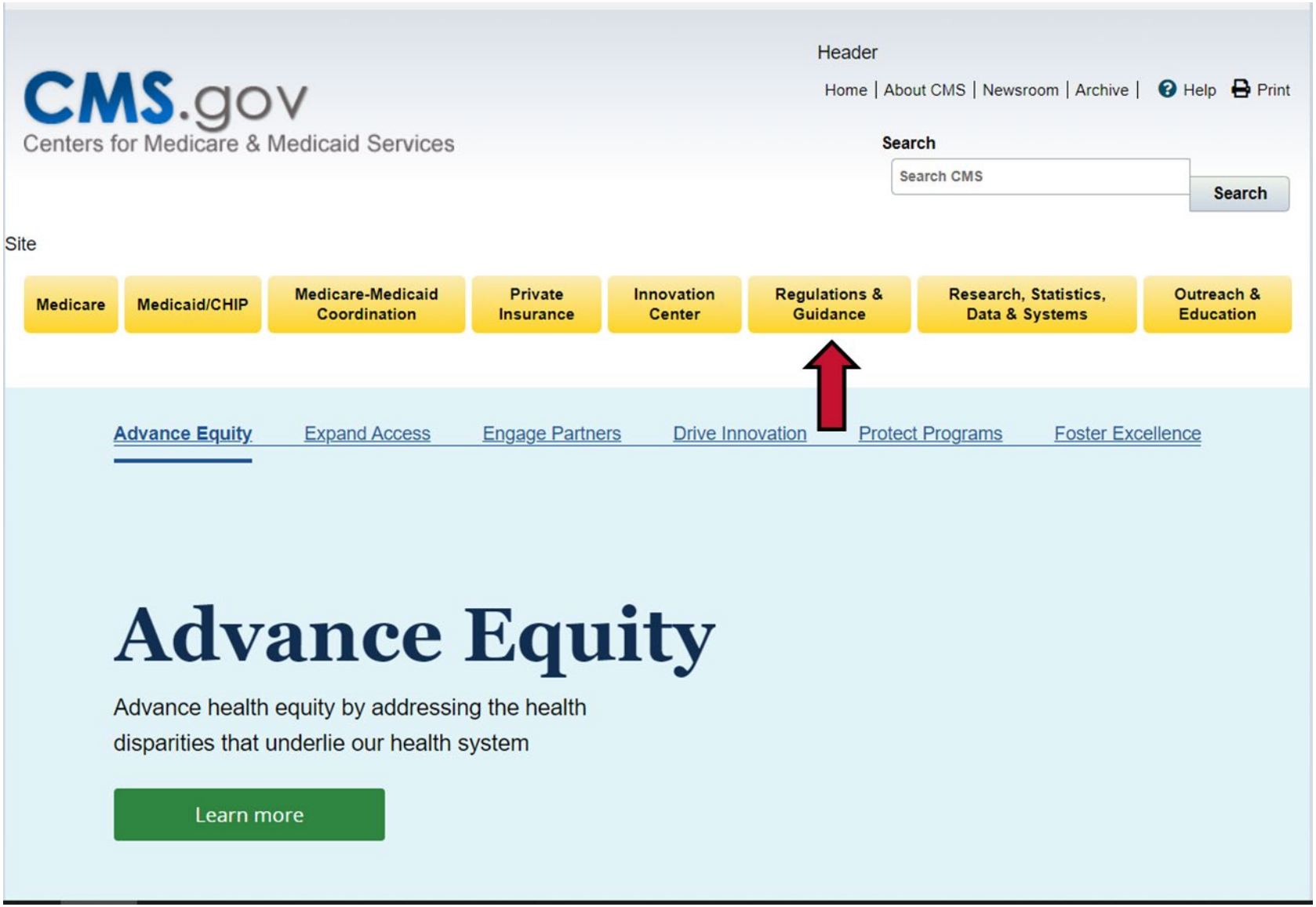
# Objectives

- Prepare Medicare providers to adapt to changes CMS implemented between 1/5/2022 and 4/4/2022

# Agenda

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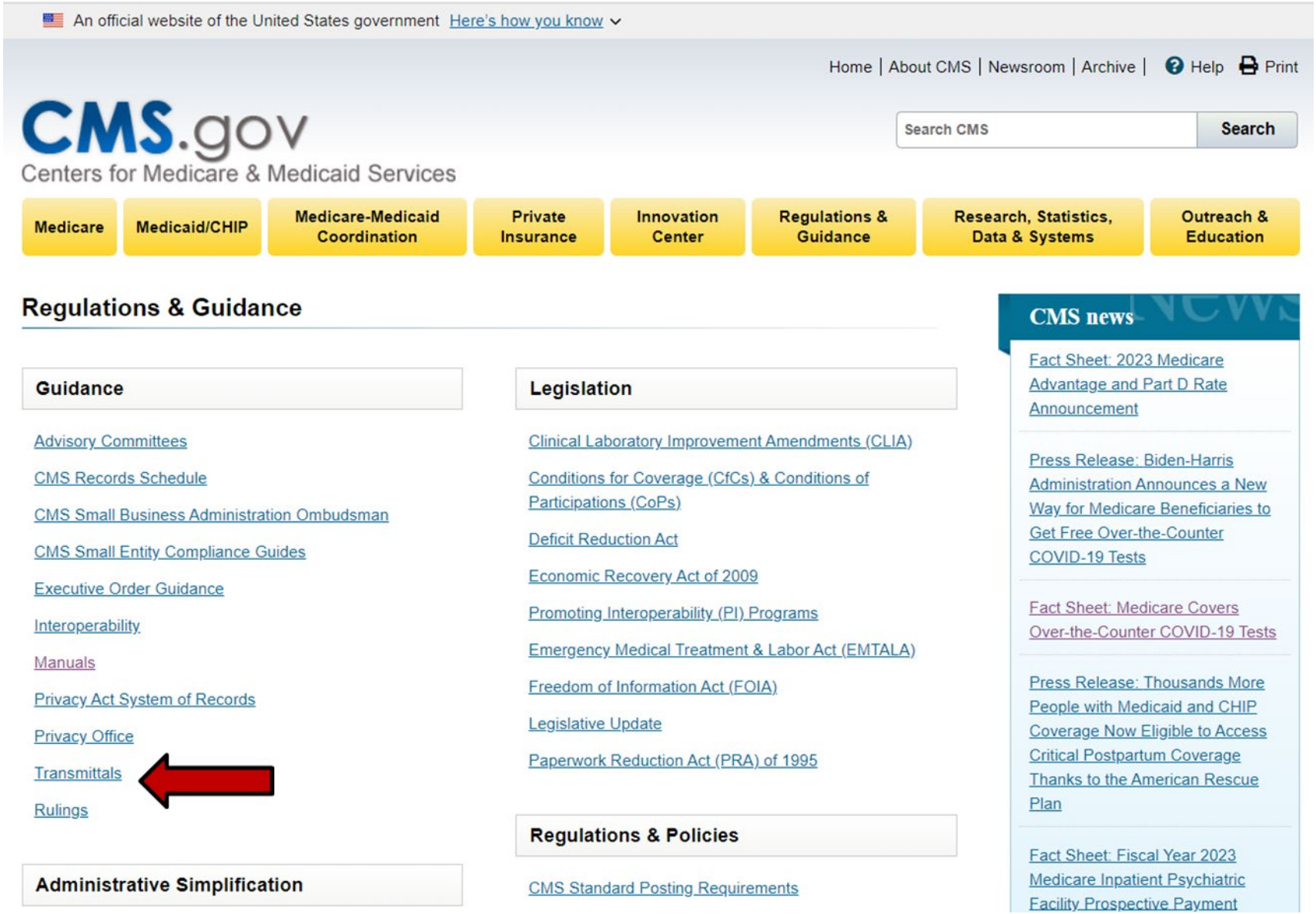


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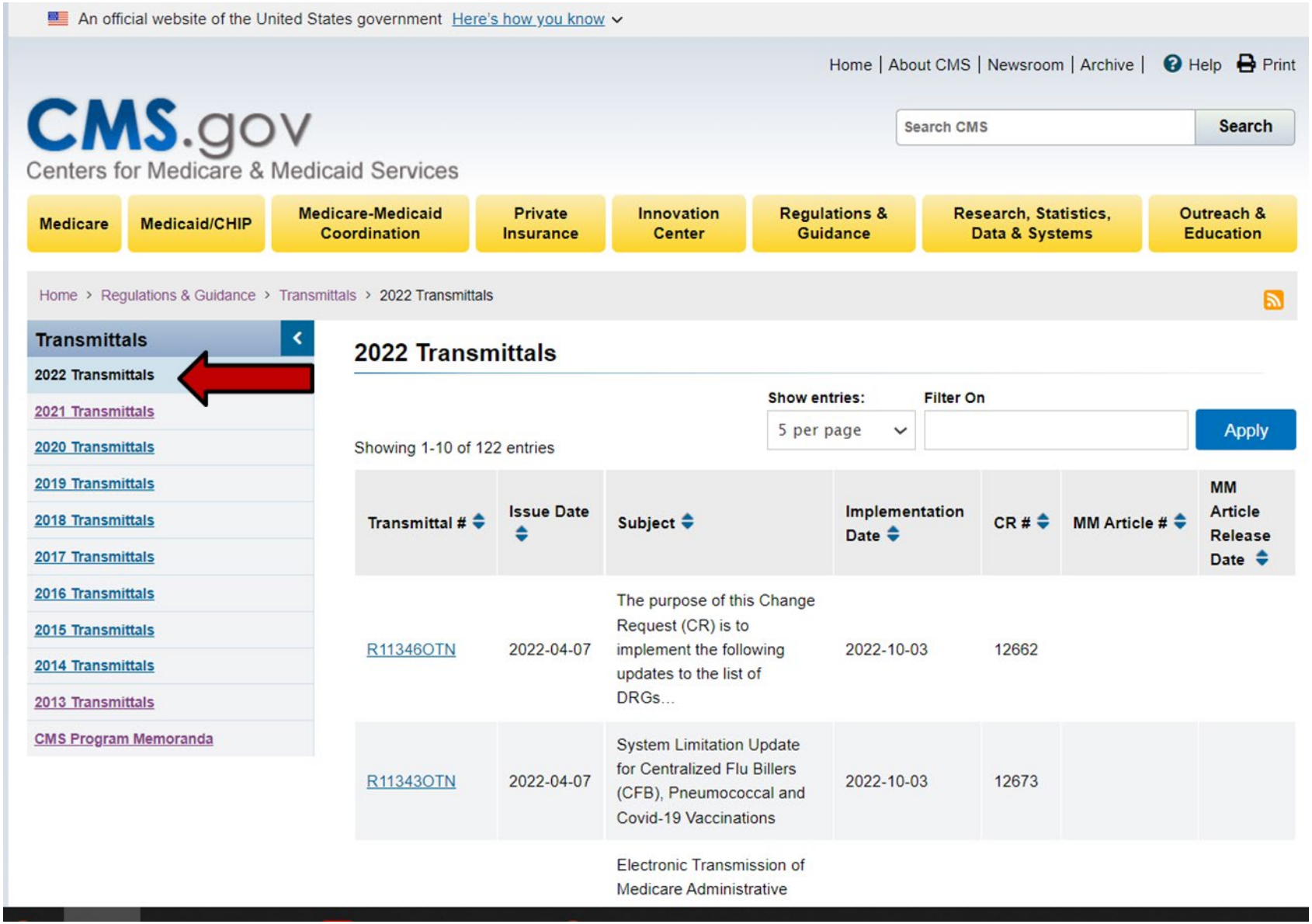


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# Change Requests

# CR 12439

- Claims Processing Instructions for the New Pneumococcal 15-valent Conjugate Vaccine Code 90671 and Pneumococcal 20-valent Conjugate Vaccine Code 90677
  - Implemented: 4/4/2022
  - Effective: 7/1/2022 & 7/16/2022
- New codes in 2021 MPFSD file update, annual HCPCS update
  - CMS Vaccines Pricing webpage

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# CR 12439

- Paid reasonable cost for the following facilities
  - Hospitals (TOB 12X, 13X)
  - SNF (TOB 22X, 23X)
  - HHA (TOB 34X)
  - Hospital-based Renal Dialysis Facilities (RDF) (TOB 72X)
  - CAH (TOB 85X)
- Coinsurance and deductible do not apply

# CR 12439

- Paid lower of the actual charge or 95% of AWP for the following facilities
  - CORF (TOB 75X)
  - Independent RDFs (TOB 72X)
  - IHS Hospitals (TOB 12X, 13X)
  - IHS Hospices (TOBs 81X, 82X)
  - IHS CAHs (TOB 85X)
- Coinsurance and deductible do not apply

# CR 12439

- Mass adjustment for claims that rejected with HCPCS 90677
  - DOS 7/1/2021-9/30/2021
  - DOS 7/16/2021-3/31/2022

# CR 12471

- April 2022 Update to the Java MCE for New Edit 20- Unspecified Code Edit
  - Implemented: 4/4/2022
  - Effective: 4/1/2022 (date of discharge)
- Applies when unspecified code is reported
  - CC or MCC
  - Includes other codes that specify anatomic site

# CR 12471

- Applies to TOB 11X, 18X, 21X
- Use Remarks if
  - Laterality not available in medical record documentation or any other clinical provider
    - Report “unable to det lat 1”
  - Record indicates physician is clinically unable to decide laterality due to nature of disease or condition
    - Report “unable to det lat 2”

# CR 12478

- RARC, CARC, MREP and PC Print Update
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
- ASC X12 website

# CR 12485

- April 2022 HCPCS Quarterly Update Reminder
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
- Alphanumeric index and table of drugs posted to the CMS website February 2022

# CR 12501

- Update to SNF PDPM Claims Containing Non-Covered days
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
- Modifies claims processing to account for non-covered days correctly and resets the variable per diem

# CR 12505

- Claim Status Category and Claim Status Codes Update
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
- Code sets available on ASC X12 website
- Include specific details, including date when code was added, changed, or deleted

# CR 12543

- IOM for Critical Care, Split/Shared Evaluation and Management Services, Teaching Physicians, and Physician Assistants
  - Implemented: 2/15/2022
  - Effective: 1/1/2022
- Updates Claims Processing and Benefit Policy Manuals

# CR 12543

- Claims Processing Manual revisions
  - Changes related to critical care services
    - Allows hospital billing for E/M visits on the same day as critical care services
  - SNF E/M visits may be billed as split (shared) visits, except when required to be performed in their entirety by a physician
  - Information on split (shared) visits
  - New modifiers –FS and –FT required for split (shared) visits and critical care services unrelated to global surgery

# CR 12543

- Teaching physicians may use only MDM to select E/M visit level when billing under PFS for office/outpatient E/M visits under primary care exception
- Only count time spent by teaching physician performing qualifying activities listed by CPT
  - Includes when teaching physician is present with resident performing
- PA's NPI can be reported for direct payment to the PA for professional services

# CR 12543

- Benefit Policy Manual revisions
  - PAs can bill under their NPI and be paid directly for professional services

# CR 12545

- Updates to Medicare Benefit Policy Manual and Medicare Claims Processing Manual for Opioid Treatment Programs and New Modifier for Audio-only Services
  - Implemented: 3/1/2022
  - Effective: 1/1/2022
- OTPs can furnish individual and group therapy and substance use counseling using audio-only telephone calls

# CR 12545

- After PHE ends, report modifier with therapy add-on HCPCS code G2080
  - -FQ (audio-only service) required when audio-only used
  - -95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) required when two-way audio/video communication used
- Report HCPCS code G2080 without -FQ or -95 modifiers to indicate in-person counseling

# CR 12549

- CY2022 Telehealth Update Medicare Physician Fee Schedule
  - Implemented: 4/4/2022
  - Effective: 1/1/2022
- Services for diagnosis, evaluation, or treatment of mental health disorders may be offered via telehealth
- Originating site includes patient's home

# CR 12549

- Audio-only communication allowed for telehealth mental health services to established patients in their homes
- After PHE ends, telehealth mental health services include new or established patients
  - In-person, face-to-face, non-telehealth service must take place within six months of telehealth mental health service
  - After initial six-month in-person visit, subsequent non-telehealth in-person visit within 12 months required

# CR 12549

- New telehealth mental health service modifiers
  - FQ (telehealth service furnished using audio-only communication)
  - FR (supervising practitioner present through audio/video communication)
- Telehealth originating site facility fee HCPCS code Q3014 adjusted to $27.59

# CR 12549

- ICR codes G0422 and G0423, and CR codes 93797 and 93798 assigned as Category 3 codes
  - Available through December 2023

# CR 12550

- IOM Updates for Critical Care Evaluation and Management Services
  - Implemented: 2/22/2022
  - Effective: 1/1/2022
- Claims Processing Manual updates
  - Separate payment may be made for critical care visits unrelated to procedure with global surgical period
  - Modifier -FT requirement

# CR 12567

- Quarterly Update to the NCCI PTP Edits, Version 28.1, Effective 4/1/2022
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
- MEC Edit file consolidated into the Column 1/Column 2 Correct Coding Edit file

# CR 12578

- April 2022 Update to the MS-DRG Grouper and MCE Version 39.1 for the ICD-10 Diagnosis Codes for 2019 COVID-19 Vaccination Status and ICD-10 PCS Codes for Introduction or Infusion of Therapeutics and Vaccines for COVID-19 Treatment
  - Implemented: 4/4/2022
  - Effective: 4/1/2022

# CR 12578

- Three new diagnosis codes for reporting COVID-19 vaccination status
  - Z28.310, Z28.311 and Z28.39
- 7 new ICD-10-PCS codes describe introduction or infusion of therapeutics, including vaccines for COVID-19 treatment included in Code Tables, Index, and related Addenda files in 2022 ICD-10-PCS

# CR 12578

- Additional Information: Medicare Billing for COVID-19 Vaccine Shot Administration
- IPPS/LTCH new MCE: When other codes are available in that subcategory, MCE edit will edit for “unspecified” ICD-10-CM diagnosis

# CR 12578

- Table 6B - New Procedure Codes - FY 2022 corrected relevant to CAR T-cell and other immunotherapies
  - Inadvertently omitted pre-MDC MS-DRG 018 in Column E (MS-DRG) for assignment of procedure codes XW033A7 and XW043A7
  - Conforming changes made to
    - ICD-10-CM/PCS MS-DRG v39.0 Definitions Manual
    - MS-DRG Classifications and Software

# CR 12583

- Quarterly Update to the ESRD PPS
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
- New code J0879 Injection, difelikefalin, 0.1 microgram, (for ESRD on dialysis)

# CR 12583

- Report J0879 with modifier AX
- Currently is the only drug that Qualifies for TDAPA
- Does not qualify toward outlier payment
- Modifier JW can be used as secondary modifier to report wastage
- Included in existing ESRD PPS functional category of antipruritic
  - Does not qualify for separate payment
  - Subject to ESRD CB - Line item processed as covered with no separate payment
- Always used for the treatment of ESRD

# CR 12583

- CR12583 – Attachment A contains current list:
  - CY 2022 ESRD PPS Consolidated Billing List
  - Labs Subject to ESRD Consolidated Billing
  - Drugs Subject to ESRD Consolidated Billing
- Additional:
  - ESRD PPS Consolidated Billing
  - ESRD PPS Outlier Services
  - ESRD PPS Transitional Drug Add-on Payment Adjustment (TDAPA)

# CR 12606

- ICD-10 and Other Coding Revisions to NCDs - July 2022
  - Implemented: 3/12/2022 (MAC); 7/5/2022 (Shared System)
  - Effective: 7/1/2022
- No policy-related changes
- Coding changes: NCD spreadsheets

# CR 12606

- Impacted NCDs:
  - NCD 20.4 Implantable Cardiac Defibrillators (ICDs)
  - NCD 160.18 Vagus Nerve Stimulation (VNS)
  - NCD 190.1 Histocompatibility Testing
  - NCD 30.3.3 Acupuncture for Chronic Low Back Pain
  - NCD 150.3 Bone Mineral Density Studies
  - NCD 110.24 CAR T-Cell Therapy

# CR 12612

- Quarterly Update for CLFS and Laboratory Services Subject to Reasonable Charge Payment
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
- CMS PAMA Regulations
- New PLAs codes: refer to table in CR 12612

# CR 12612

- Next CLFS Data Reporting Period for Clinical Diagnostic Laboratory Tests
  - Data reporting period 1/1/2023 through 3/312023 will be based on original data collection period of 1/1/2019 through 6/30/2019
  - Subsequent data reporting
    - Three-year data reporting cycle for CDLTs that are not ADLTs
      - 2026, 2029, and so on

# CR 12623

- Quarterly Update to the MPFSDB - April 2022 Update
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
- Codes added to MPFSDB effective DOS on/after 1/1/2022
  - 0071A, 0072A, 91307,J0248, M0220, M0221, Q0220

# CR 12623

- Codes added to MPFSDB effective DOS on/after 4/1/2022
  - A2011 – A2013, A4100, A4238, A9291, A9574, H2038, J0219, J0491, J0897, J9071, J9273, J9359, Q4224, Q4225, Q4256 – Q4258, Q5124, T2050, T2051, V2525
- Codes with procedure status changed to 1
  - A9276, A9277, A9278

# CR 12628

- The SSI/Medicare Beneficiary Data for FY 2020 for IPPS Hospitals, IRFs, and LTCHs
  - Implemented: 3/25/2022
  - Effective: 3/25/2022

# CR 12628

- SSI/Medicare beneficiary data for hospitals – updated Medicare files available:
  - IPPS: CMS Disproportionate Share Hospital (DSH)
  - IRF: CMS IRP PPS SSI Data
  - LTCH: CMS LTCH PPS Other Files for Download

# CR 12631

- April 2022 Update to the FY 2022 IPPS
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
- NCTAP
  - Effective 11/2/2020 until end of FY that PHE ends
  - Impacts cases using new COVID-19 treatments under IPPS PPS
    - New COVID-19 Treatments Add-On Payment (NCTAP)

# CR 12631

- NGS will reprocess inpatient claims meeting all of the following criteria, when brought to our attention:
  - Discharge date on or after 12/23/2021
  - Condition Code ZA not present
  - ICD-10-CM diagnosis code U07.1 (COVID-19)
  - NDC 00069-1085-06 or NDC 00069-1085-30

  Or,
  - Discharge date on or after 12/22/2021
  - Condition Code ZA not present
  - ICD-10-CM diagnosis code U07.1 (COVID-19)
  - NDC 00006-5055-06 or NDC 00006-5055

# CR 12648

- April 2022 I/OCE Specifications Version 23.1
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
- Shows HCPCS, APC, HCPCS Modifier, and Revenue Code additions, changes, and deletions
  - I/OCE Quarterly Release Files
  - Also refer to CR12666

# CR 12666

- April 2022 Update of the Hospital OPPS
  - Implemented: 4/4/2022
  - Effective: 4/1/2022
  - New Covid-19 CPT Vaccines and Administration Codes
    - Effective 1/3/2022: Vaccine product HCPCS code 91305 and administration HCPCS codes 0051A, 0052A, 0053A and 0054A (tris-sucrose formulation of Pfizer BioNTech COVID-19 vaccine)
    - Effective 1/3/2022: CPT code 0073A (third pediatric dose - Pfizer BioNTech COVID-19 vaccine)

# CR 12666

- On 2/1/2022, the AMA released new CPT Category I codes to report immunization administration
- New codes pending EUA/FDA approval: 0081A and 0082A (Pfizer First and Second Dose SARS-CoV-2 vaccine for pediatric patients ages six months through up to five years of age) and 91308 (new Pfizer pediatric vaccine product)

- COVID-19 Monoclonal Antibody Therapy Product and Administration Code changes
  - Effective 12/8/2021: Level II codes for EVUSHELD™ and its affiliated injections Q0220, M0220 and M0221
  - Effective 2/24/2022: new code Q0221 - EVUSHELD™ for 300 mg of tixagevimab and 300 mg of cilgavimab
  - COVID-19 Monoclonal Antibodies

# CR 12666

- 17 new CPT PLA Coding Changes:
  - Table 3 – contains the codes, long descriptors and SIs
- Updated list of procedure codes associated with HCPCS code C1748
  - Bill C1748 with one of following procedure codes
    - 0652T, 0653T, 0654T, 43197, and 43198
- New separately payable procedure codes
  - C9782 and C9783

# CR 12666

- New code C9781: implantation of saline-filled balloon for shoulder to treat irreparably torn rotator cuff tendons
- Reassigned codes 66989 and 66991 to APC 1563 retroactive to 1/1/2022
- New codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status: C9090 - C9093 and J9273

# CR 12666

- Current codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status: C9088, J0248, J9304
- New HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals
  - C9090 - C9093, J0219, J0248, J0491, J0879, J9071, J9273, J9359, Q5124
- Code A2003 is deleted retroactive to 1/1/2022
- Code M1145 is deleted retroactive to 2/28/2022

# CR 12666

- Rabies vaccine code 90377 retroactive change to payable effective 1/1/2021
- Hepatitis B vaccine code 90759 retroactively payable at reasonable cost effective 1/11/2022
- New skin substitute products
  - Assigned to Low Cost Group: A2011 – A2013, A4100, Q4224, Q4225, Q4256 - Q4258
  - Assigned to High Cost Group: Q4199

# CR 12666

- Skin substitute products reassigned to High Cost Group: Q4199, A2001, A2002, A2004 - A2010
- New blood product: C9507 - Plasma, high titer COVID-19 convalescent, each unit; assigned APC 9540
  - Retroactive payment APC 1509 effective 12/28/2021 until 3/31/2022
- Billing devices under OPPS
  - Revised CMS IOM 100-04, Chapter 4, Section 61.1

# CR 12666

- Procedure code requiring device code but no specific HCPCS code applies, report HCPCS code C1889 and charges

- Reminders:
  - Status indicators, APCs, and payment rates for specific HCPCS codes: April 2022 OPPS Addendum B
  - SI/definitions: OPPS Addendum D1 in CY 2022 OPPS/ASC final rule (2022 NFRM OPPS Addenda)

# Special Edition Article SE22001

- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
  - Released: 3/30/2022
  - Effective 1/1/2022, RHC/FQHC can provide mental health visits using interactive, real-time telecommunications technology
  - Do not bill HCPCS code G2025 for mental health visit provided via telecommunications
    - SE20016 discusses billing G2025 for professional telehealth distant site services other than mental health visits during the PHE

# Special Edition Article SE22001

- Audio-only technology may be used when beneficiary can't access or doesn't consent to use audio-video technology
  - Bill using new service-level modifier FQ
- Mental Health Visits via Telecommunications
  - Bill using modifier 95 (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System)

# Special Edition Article SE22001

- Mental Health Visits via Telecommunications
  - RHC billing example:

| Revenue Code | HCPCS Code | Modifiers |
|---|---|---|
| 900 | 90834 (or other Qualifying Mental Health Visit Payment Code) | 95 (audio-video) or FQ (audio-only) |

  - FQHC billing example:

| Revenue Code | HCPCS Code | Modifiers |
|---|---|---|
| 900 | G0470 (or other appropriate FQHC specific Mental Health Visit Payment Code) | 95 (audio-video) or FQ (audio-only) |
| 900 | 90834 (or other appropriate FQHC specific Mental Health Visit Payment Code) | N/A |

# Special Edition Article SE22001

- In-Person Mental Health Visit Requirements
  - Apply only to patient receiving mental health visits via telecommunications at home:
    - In-person mental health visit must occur six months before telecommunications visit
    - Generally, must be an in-person mental health visit at least every 12 months while patient is receiving telecommunications services to diagnose, evaluate, or treat mental health disorders
      - Limited exceptions based on patient circumstances where risks and burdens of an in-person visit may outweigh the benefit
        - » Proper documentation of circumstance must be included in medical record

# Thank You!

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


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