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Part A FY 2023 Q2 CMS Quarterly Updates

4/25/2023

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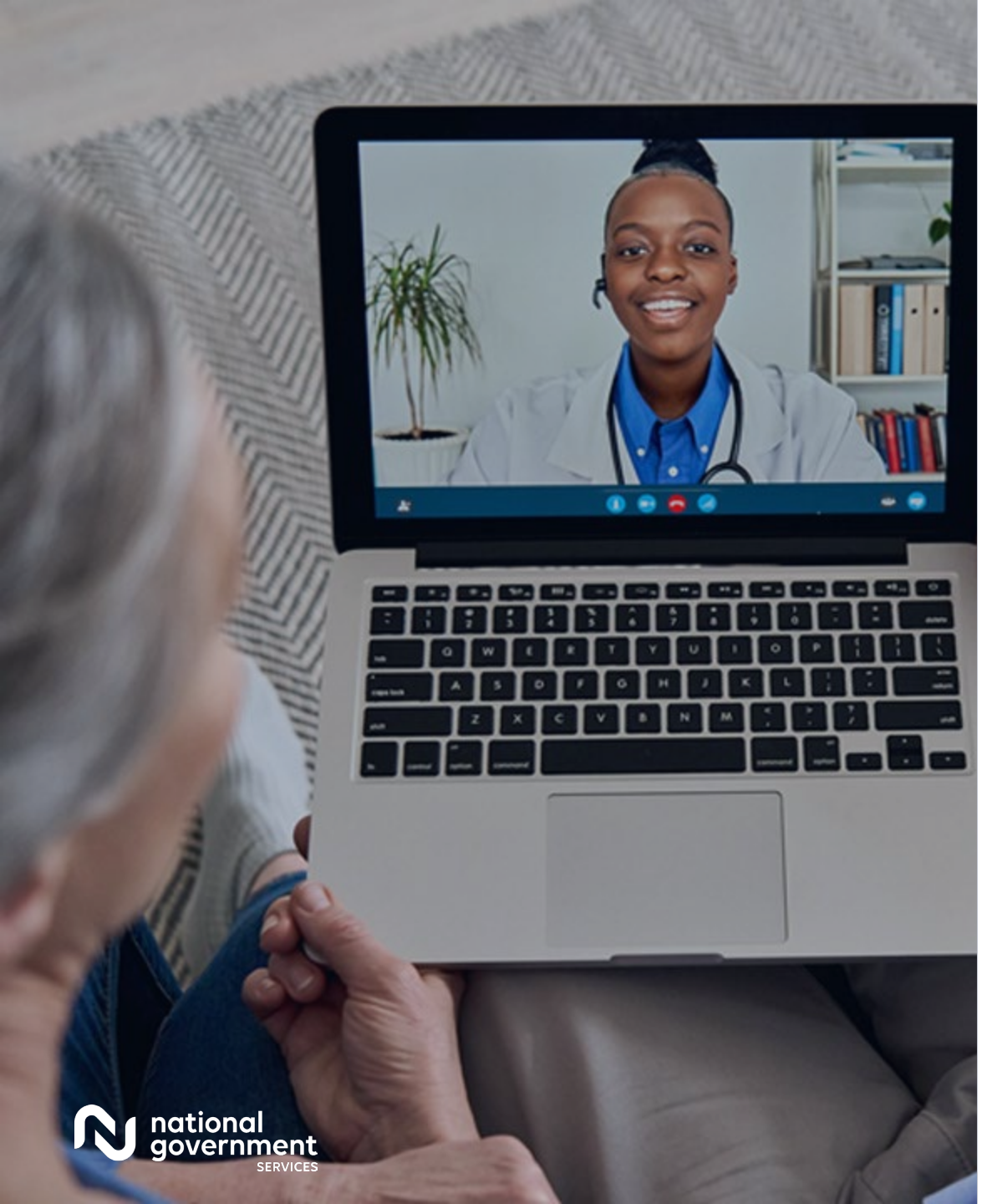

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Objective

Prepare Medicare providers to adapt to changes CMS implemented between January 4, 2023 and April 3, 2023 (unless otherwise noted).

Today's Presenters

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- Provider Outreach and Education Consultants
  - Jean Roberts, RN, BSN, CPC
  - Jhadi Grace

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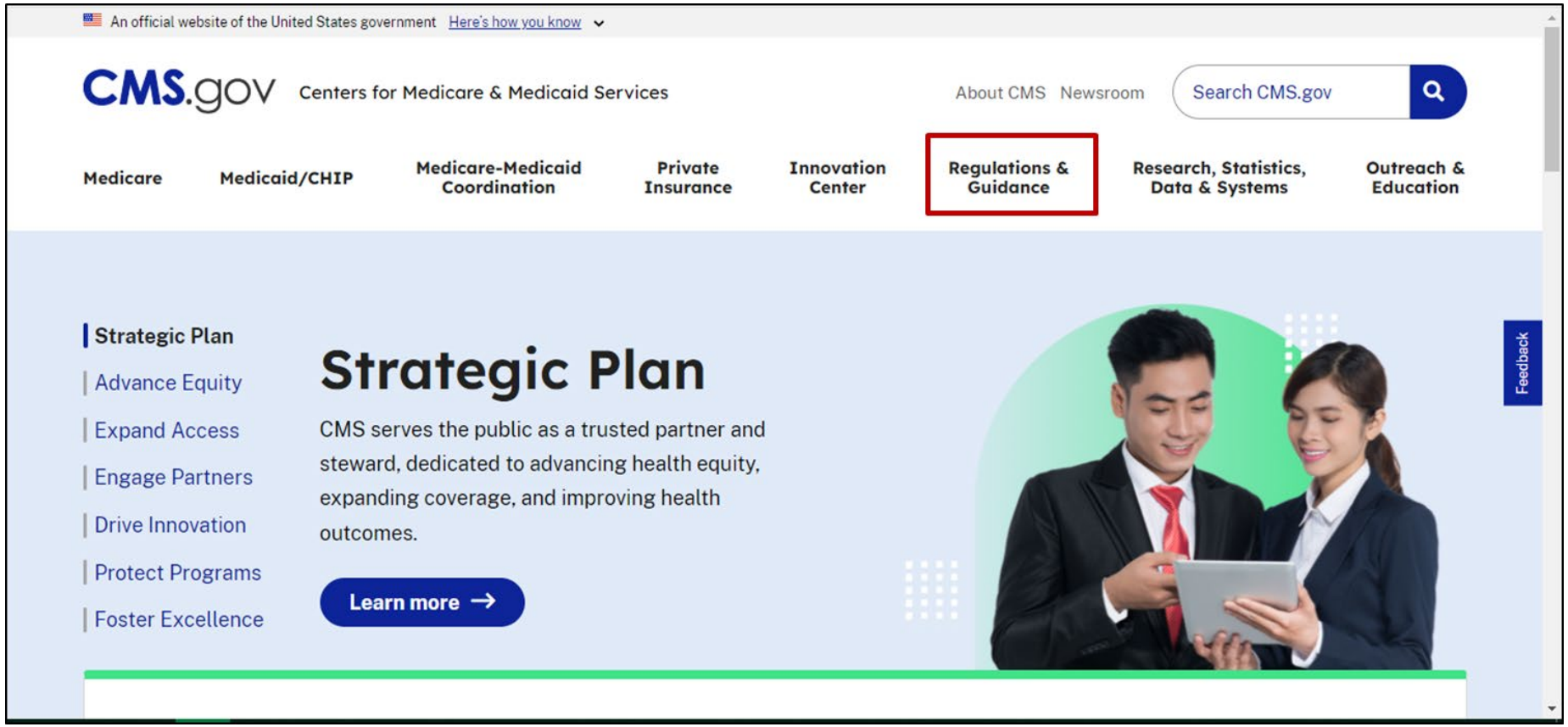
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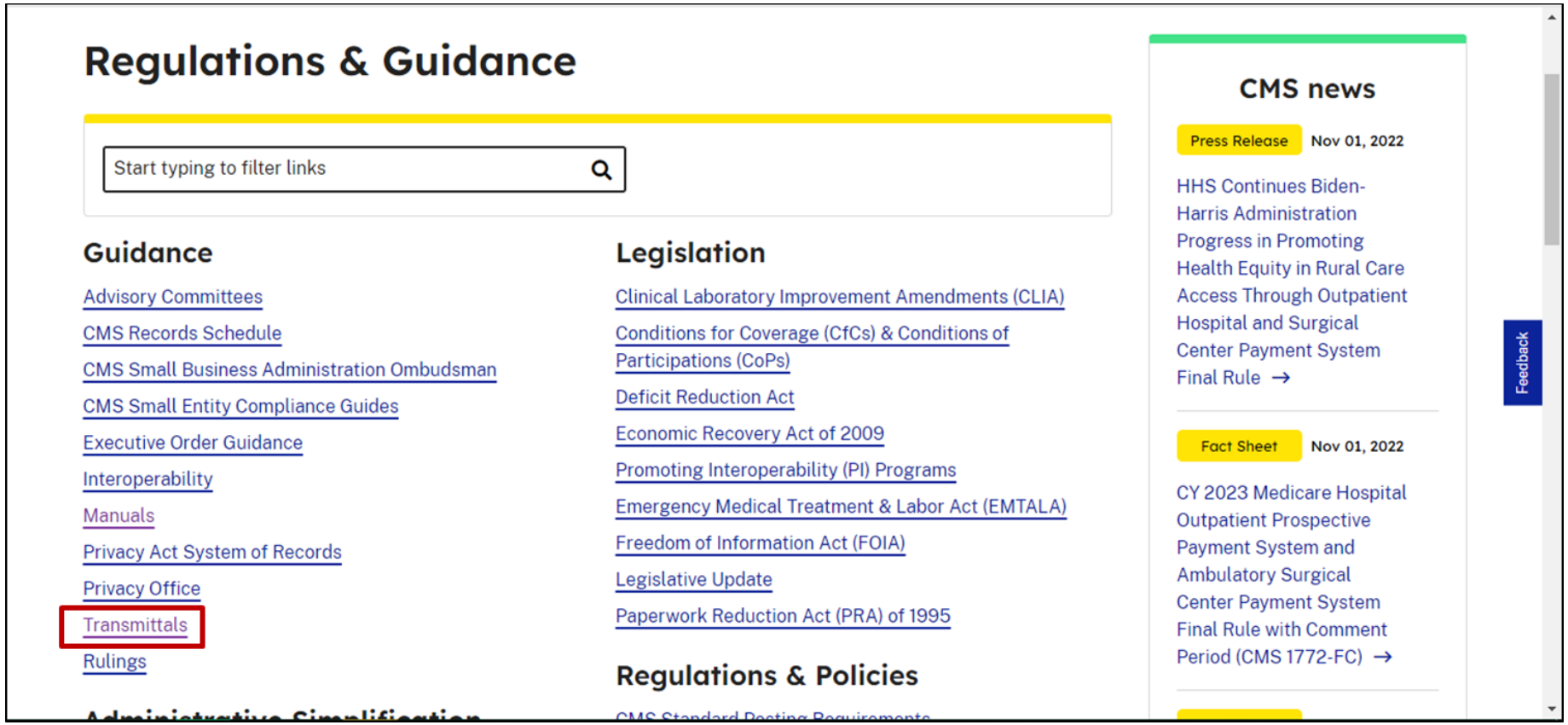

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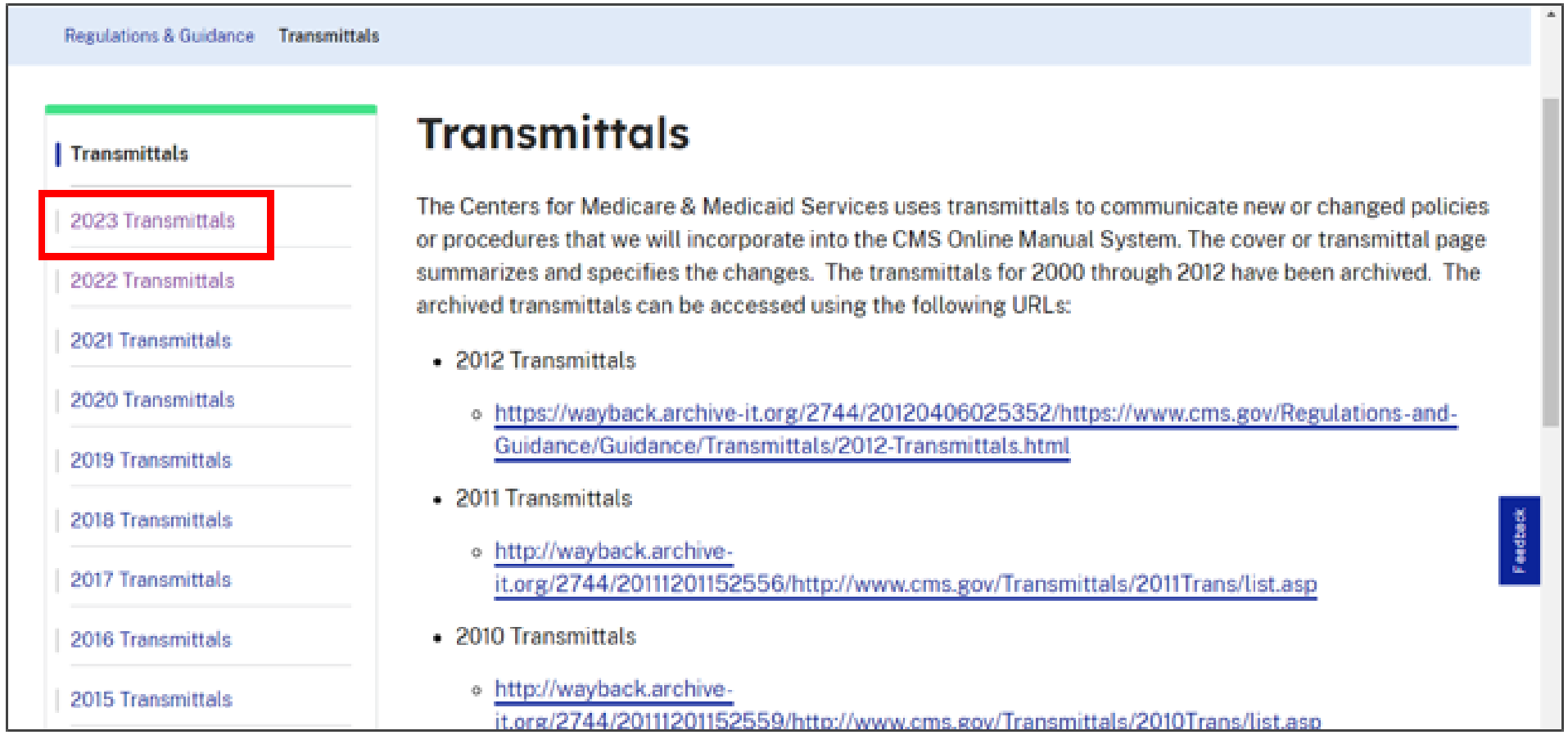
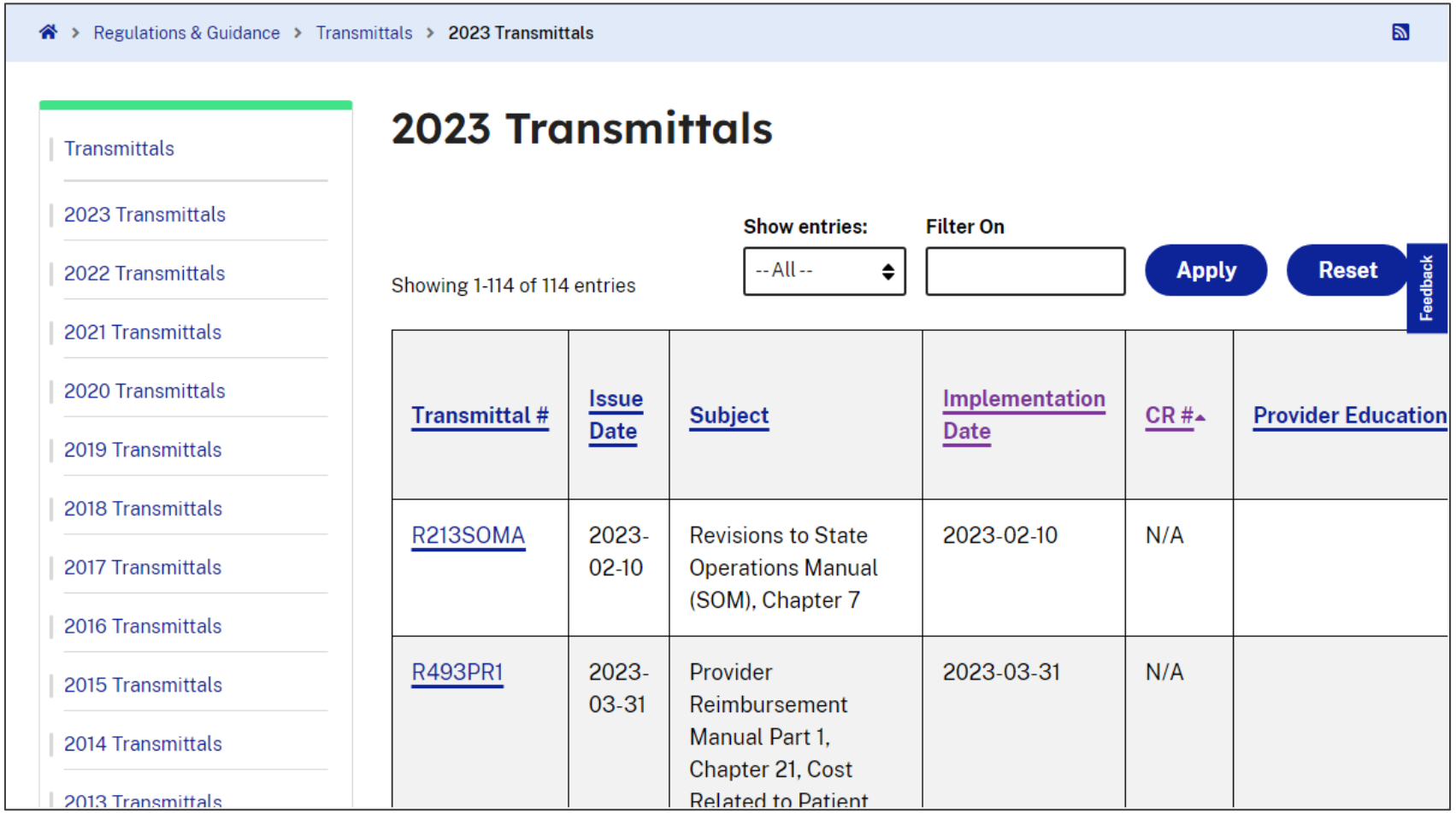


2023 Transmittals Page



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Transmittal #	Issue Date	Subject	Implementation Date	CR #	Provider Education
R213SOMA	2023-02-10	Revisions to State Operations Manual (SOM), Chapter 7	2023-02-10	N/A	
R493PR1	2023-03-31	Provider Reimbursement Manual Part 1, Chapter 21, Cost Related to Patient	2023-03-31	N/A	

Change Requests

CR 12896

- Enhancements to Patient Driven Payment Model (PDPM) Claim Edits to Improve Claim Processing
  - Implemented: 4/3/2023
  - Effective: 10/1/2019
- Applies to SNFs billing on TOB 21X
- Medicare systems won't set FY end edit when SNF submits no-pay TOB 210 or 180
- Inpatient TOB 11X and SNF TOB 21X processed and paid when 11X TOB contains condition code 40

CR 12928

- National Coverage Determination (NCD 110.24): Chimeric Antigen Receptor (CAR) T-cell Therapy
  - Implemented: 1/31/2023
  - Effective: 1/1/2022
- Part A OPPS providers don't need to change billing
  - Continue to bill one unit for CAR T-cell products
  - Use of non-FDA-approved autologous T-cells with at least one CAR continues to be noncovered
  - Autologous treatment for cancer with T-cells expressing at least one CAR is also noncovered when the NCD criteria aren't met
  - Use of allogenic T-cells from healthy donors aren't autologous CAR T-cell treatments; do not bill those as autologous CAR-T treatments

CR 12943

- Implementation of a National Fee Schedule for Medicare Part B Vaccine Administration CMS
  - Implemented: 4/3/2023
  - Effective: 1/1/2023
- CMS updates the Part B payment amount for preventive vaccine administration every year
  - CY 2022: $30 for administration of influenza, pneumococcal, or HBV vaccine
  - CY 2022: $40 for the administration of COVID-19 vaccines, add-on payment of $35.50 when administering COVID-19 vaccine in patient's home
  - Information about payment for preventive vaccine administration effective for CY 2023 is available in the CY 2023 Physician Fee Schedule final rule

CR 12949

- April 2023 Healthcare Common Procedure Coding System (HCPCS) Quarterly Update Reminder
  - Implemented: 4/3/2023
  - Effective: 4/1/2023
- Quarterly update to HCPCS file available to download
  - HCPCS Quarterly Update

CR 12960

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--April 2023 Update
  - Implemented: 4/2/2023
  - Effective: 4/1/2023
- Relevant NCD coding changes
  - NCD 20.4 – Implantable Automatic Defibrillators (ICDs) (Effective 10/1/2022)
  - NCD 210.10 – Screening for STIs (Effective 10/1/2022)

CR 12988

- New State Codes for North Carolina and other States
  - Implemented: 4/3/2023
  - Effective: 4/1/2023
- New State Codes in addition to existing codes

North Carolina (NC) – B6	Alabama (AL) – B7	Northern Mariana Islands (MP) – B8	Delaware (DE) – B9
District of Columbia (DC) – C0	Florida (FL) – C1	Georgia (GA) – C2	Guam (GU) – C3
Illinois – (IL) - C4	Indiana (IN) – C5	Maine (ME) – C6	Michigan (MI) – C7
Mississippi (MS) – C8	Missouri (MO) – C9	Nebraska (NE) – D0	New York (NY) – D1
Ohio (OH) – D2	Pennsylvania (PA) – D3	South Carolina (SC) – D4	Virginia (VA) – D5

CR 12992

- Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 1, Section 90, to include Critical Access Hospitals (CAHs) for a Portion of a Medicare Advantage (MA) Billing Period
  - Implemented: 1/11/2023
  - Effective: 1/11/2023
- For hospitals exempt from PPS, including CAHs
  - If the MA organization has processing jurisdiction for the MA involved portion of the bill, it will direct the provider to split the bill and send the appropriate portions to the appropriate MAC or MA organization
  - When forwarding a bill to an MA organization, the provider must also submit the necessary supporting documents

CR 13016

- Provider Education for Prior Authorization (PA) Process for Facet Joint Interventions in the Hospital Outpatient Department (OPD) Setting
  - Implemented: 2/15/2023
  - Effective: 2/15/2023
- CMS added facet joint interventions to the prior authorization process for hospital outpatient department services
- Providers must request prior authorization for this service category effective for dates of service beginning 7/1/2023

CR 13017 (1)

- An Omnibus CR to Implement Policy Updates in the CY 2023 PFS Final Rule, Including Removal of Selected NCDs (NCD 160.22 Ambulatory EEG Monitoring) and Expanding Coverage of Colorectal Cancer Screening – Full Agile Pilot CR
  - Implemented: 2/27/2023
  - Effective: 1/1/2023
- Removed NCD 160.22 – Ambulatory EEG Monitoring

CR 13017 (2)

- Lowered the minimum age for colorectal cancer screening (CRC) from age 50 to 45 for certain tests (HCPCS codes G0104, G0106, G0120, G0327, G0328, 81528 and 82270)
  - Screening Flexible Sigmoidoscopy Test
  - Screening Guaiac-based Fecal Occult Blood Test (gFOBT)
  - Screening Immunoassay-based Fecal Occult Blood Test (iFOBT)
  - Screening The Cologuard™ – Multi-target Stool DNA (sDNA) Test
  - Screening Barium Enema Test
  - Screening Blood-based Biomarker Tests
- Screening colonoscopy has no minimum age limitation
- No modification on maximum age limit

CR 13017 (3)

- CRC screening tests now include follow-on screening colonoscopy after a Medicare-covered, noninvasive, stool-based CRC screening test returns positive result
  - Following colonoscopy need not be diagnostic colonoscopy
  - Cost sharing won't apply
  - Frequency limitations won't apply to follow-on screening
- Report modifier – KX to indicate service performed as follow-on screening after positive result
- Updates *Benefit Policy Manual, Claims Processing Manual, NCD Manual*

CR 13044

- April 2023 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
  - Implemented: 4/3/2023
  - Effective: 4/1/2023
- Announces 27 prescription drugs for which Part B beneficiary coinsurances may be lower from 4/1/2023-6/30/2023
  - Quarterly ASP public file
  - Quarterly ASP Fact Sheet
  - Initial Guidance Detailing the Requirements and Procedures for the Medicare Prescription Drug Inflation Rebate Program

CR 13062

- Updates to Medicare Benefit Policy Manual and Medicare Claims Processing Manual for Opioid Treatment Programs and Additional Claims Modifier for Audio-only Services
  - Implemented: 2/21/2023
  - Effective: 1/1/2023
- Updates manuals to reflect policies finalized in CY 2020 and CY 2023 PFS final rules
  - OTP mobile units considered for determining payments to OTPs
  - Initiation of treatment with buprenorphine via OTP intake add-on code may be furnished via two-way audio-video technology
  - Periodic assessments can be furnished audio-only during PHE and through end of CY2023

CR 13063

- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update
  - Implemented: 2/27/2023
  - Effective: 1/1/2023
- Information revised or clarified for RHCs and FQHCs
  - Mental health visit may use interactive, audio-video telecommunications
  - TCM and general care management services can be provided for same patient during same service period
  - During hospice election, visit location may include patient's residence
  - Physician, NP, PA may provide hospice attending services when practitioner is not working for RHC or FQHC

CR 13063

- COVID-19 vaccinations and monoclonal antibody products covered
- In-person visit requirements for mental health telehealth services start on 1/1/2025
- Chronic pain management (CPM) services covered
- CPM services paid when minimum of 30 minutes or qualifying non-face-to-face CPM services provided during a calendar month
- Chronic Care Management (CCM), Principal Care Management (PCM), CPM and general Behavioral Health Integration (BHI) services reported by HCPCS code G0511 and paid separately when billed alone or with other payable services
- National payment limit for RHCs is $126

CR 13070

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations: July 2023 Update
  - Implemented: 3/3/2023
  - Effective: 3/1/2023
- Relevant NCD coding changes
  - NCD 20.4 – Implantable Cardiac Defibrillators (ICDs)
  - NCD 20.7 – Percutaneous Transluminal Angioplasty (PTA)
  - NCD 20.20 – External Counterpulsation Therapy
  - NCD 150.3 – Bone Density Studies
  - NCD 150.10 – Lumbar Artificial Disc Replacement (LADR)
  - NCSD 210.1 – Prostate Cancer Screening
  - NCD 220.13 – Percutaneous Image-Guided Breast Biopsy

CR 13071 (1)

- Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens and New Updates for 2023
  - Implemented: 1/23/2023
  - Effective: 1/1/2023
- CY 2023 general specimen collection fee = $8.57
  - Increased by $2.00 for specimens collected from SNF patient or by lab on behalf of HHA ($10.57)
  - To be eligible, the specimen must be
    - ✓ Used to perform CDLT paid under CLFS regulations
    - ✓ Collected by trained technician from homebound patient or nonhospital inpatient
    - ✓ Collected through venipuncture or catheterization
  - One collection fee allowed for each type of specimen per patient encounter

CR 13071 (2)

- Travel allowance mileage rate for CY 2023 = $1.11
  - Flat rate allowance applies when travel is 20 eligible miles or less
    - ✓ Report HCPCS code P9604, prorated by number of patients specimen collection fee is paid
    - ✓ Travel allowance mileage rate x 10 ÷ number of patients
  - Per mile allowance applies when round-trip travel is greater than 20 miles or travel is to more than one location
    - ✓ Report HCPCS code P9603, prorated by number of patients specimen collection fee is paid
    - ✓ Total eligible miles x travel allowance mileage rate ÷ number of patients
- Deductible and coinsurance waived for specimen collection and travel allowance
- Claims will be adjusted by MAC

CR 13073

- National Coverage Determination (NCD) 50.3 – Cochlear Implantation Manual Update
  - Implemented: 3/24/2023
  - Effective: 9/26/2022
- Coverage of cochlear implants applies to treatment of bilateral pre- or post-linguistic, sensorineural, moderate-to-profound hearing loss in people who demonstrate limited benefit from amplification as defined by test scores of less than or equal to 60% correct in the best-aided listening condition on recorded tests of open-set sentence recognition
- May be covered when performed in context of FDA-approved category B investigational device exemption clinical trials

CR 13074

- Update to the Internet Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 10.2.2.1, to Clarify the Payment Method on Vaccines for Critical Access Hospitals (CAHs)
  - Implemented: 3/9/2023
  - Effective: 3/9/2023
- Adds IHS CAHs, TOB 12X, 85X to payment for vaccines and vaccine administration

CR 13079

- Notice of New Interest Rate for Medicare Overpayments and Underpayments – 2nd Qtr Notification for FY 2023
  - Implemented: 1/18/2023
  - Effective: 1/18/2023
- Private consumer rate changed to 11.25%

CR 13082

- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment: Quarterly Update
  - Implemented: 4/3/2023
  - Effective: 4/1/2023
- Next CLFS data reporting period for CDLTs delayed until 1/1/2024–3/31/2024
- General specimen collection fee increased to $8.57
- Specimens collected from SNF patient or by lab on behalf of HHA increased to $10.57
- HCPCS codes 0324U and 0325U discontinued 4/1/2023

CR 13085

- Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 3
  - Implemented: 3/24/2023
  - Effective: 3/24/2023
- When Medicare is secondary, provider must first submit claim to primary payer
  - Primary payer is required to process and make primary payment on claim
- Providers shall not deny medical services or entry to a SNF or hospital
  - When there is open or closed GHP or non-GHP MSP record found in HETS or CWF
  - When a claim that was previously mistakenly denied by Medicare due to MSP

CR 13085

- If services covered under open GHP or related to non-GHP MSP accident or injury, bill primary insurer first
  - Providers billing for services related to new accident or injury not related to existing non-GHP MSP record may need to use same diagnosis codes found on non-GHP record
    - ✓ Submit these claims to Medicare after submitting claim to GHP or non-GHP insurer
  - Non-GHP insurer may deny these claims if services not related to original accident
  - Medicare may deny these claims because diagnosis codes are related to those found on the non-GHP MSP record
    - ✓ Appeal these claims; provide explanation or reason code to justify why services are not related

CR 13085

- Workers' Compensation Medicare Set-Aside Agreement (WCMSA) is agreement about the value of settlement funds that must be spent for care related to all settles WC injuries/illnesses before Medicare begins primary payment
  - Condition claimed as work-related and received full-and-final settlement that included funds for future care
  - Beneficiary previously filed WC claim for same condition
  - Beneficiary indicates WCMSA exists
  - HETS 270/271 transaction shows "W" MSP WC record exists

CR 13085

- Provider should verify that “W” MSP WC record exists
  - Provider bills patient directly
  - Is WCMSA does not pay due to funds exhausted, provider bills Medicare indicating what WCMSA paid
  - Medicare may pay as primary or secondary, dependent on WCMSA status
- If no other primary payers available, provider submits
  - Claim indicating occurrence code 24 and date of denial
  - Supplementary statement reporting WCMSA denied payment and/or remarks

CR 13089

- April 2023 Quarterly Update to HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement
  - Implemented: 4/3/2023
  - Effective: 4/1/2023
- Updates the list of HCPCS codes subject to CB provision of SNF PPS
- Adds codes for blood clotting factors to Medicare Part B SNF files

CR 13092

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – April 2023 Update
  - Implemented: 4/3/2023
  - Effective: 4/1/2023
- HCPCS/CPT codes added to MPFSDB effective for DOS on/after 1/1/2023 or 4/1/2023
- Procedure code status changes effective for DOS on/after 4/1/2023

CR 13101

- The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year (FY) 2021 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)
  - Implemented: 3/24/2023
  - Effective: 3/24/2023
- Provides updated data for determining
  - Disproportionate share adjustment for IPPS hospitals
  - Low-income patient adjustment for IRFs
  - Payments for LTCH discharges

CR 13103

- Extensions of Certain Temporary Changes to the Low-Volume Hospital Payment Adjustment and the Medicare Dependent Hospital (MDH) Program under the Inpatient Prospective Payment System (IPPS) Provided by the Further Continuing Appropriations and Extensions Act, 2023, and the Consolidated Appropriations Act, 2023
  - Implemented: 3/10/2023
  - Effective: 12/17/2022
- For FY2023 and 2024, low-volume hospital must
  - Be more than 15 road miles from another hospital
  - Have less than 3,800 discharges during the FY
- MDH program extended through 9/30/2024

CR 13125

- April 2023 Integrated Outpatient Code Editor (I/OCE) Specifications Version 24.1
  - Implemented: 4/3/2023
  - Effective: 4/1/2023
- CMS posted the April 2023 Integrated Outpatient Code Editor files

CR 13136 (1)

- April 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS)
  - Implemented: 4/3/2023
  - Effective: 4/1/2023
- Updates payment systems and adds new codes
- New COVID-19 CPT Vaccines and Administration Codes
  - 91316 (“Moderna COVID-19 Vaccine, Bivalent”)
  - 0164A (administration of 91316)
  - 91317 (“Pfizer-BioNTech COVID-19 Vaccine, Bivalent”)
  - 0173A (administration of 91317)
- After PHE, payment for COVID-19 treatments packaged into C-APC payment

CR 13136 (2)

- CPT PLA Coding Changes
  - 23 new PLA codes including CPT codes 0364U through 0386U
- New Device Pass-Through Categories
  - Added HCPCS codes C1747, C1826, C1827
  - Deleted HCPCS codes C1834

Questions?

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