National Government Services

A CMS Medicare Administrative Contractor

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Monthly Review

Issue No. MMR 2020-09 October 2020

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CMS MLN Connects® Weekly Provider eNews

Medical Review Focus Area for the Latest Articles

Contact information can be found on our website.
Medicare policies can be accessed from the Medical Policy Center section of our website. Providers without access to the Internet can request hard copies from National Government Services.

This bulletin should be shared with all health care practitioners and managerial members of the providers/suppliers staff. Bulletins issued during the last two years are available at no cost from our website.

CMS publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform providers and suppliers:

- Regulations and major policies under development during the quarter
- Regulations and major policies completed or cancelled
- New or revised manual instructions

October 2020 Fiscal Intermediary Standard System Direct Data Entry Screen Changes

The Direct Data Entry (DDE) Common Working File (CWF) Inquiry Screen (MAP175M) will display the ambulatory blood pressure monitoring (ABPM) and will include the technical and professional dates for Healthcare Common Procedure Coding System (HCPCS) 93784.

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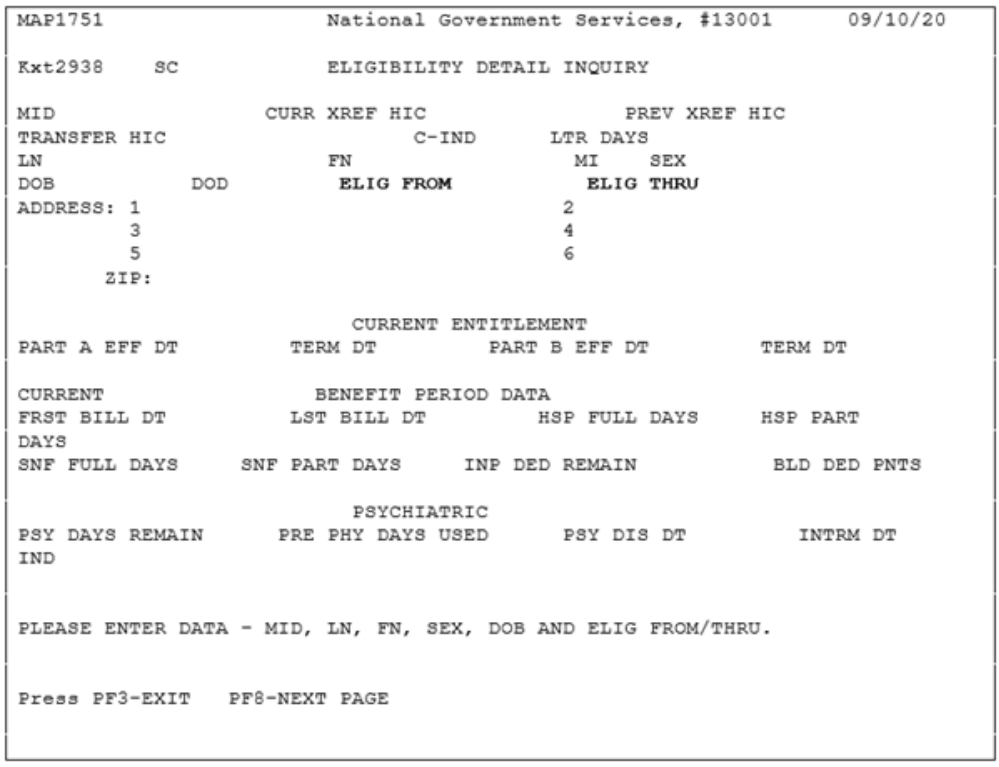
                    National Government Services, #13001

MAP175M                                                          06/26/19
SC                          ACCEPTED                             13:10:37
MID                 NM           IT     DB 08041943   SX F
PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF D ¦ PRVN SERVC TECH D PROF
D
TELH/99231 010111 010111   BONE/77085 080108 080108
TELH/99232 010111 010111   COCS/      AGE
TELH/99233 010111 010111   LDCT/G0297 041315 SRV
TELH/99307 010111 010111   HPVS/G0476 092816 092816
TELH/99308 010111 010111   HIVS/
TELH/99309 010111 010111   BONE/0508T 080108 080108
TELH/99310 010111 010111   BONE/0554T 100219 100219
BEHV/G0442         090113  BONE/0555T 100219 100219
BEHV/G0443         090612  BONE/0556T 100219 100219
BEHV/G0444 101411 101411   BONE/0557T 100219 100219
BEHV/G0446 110811 110811   BONE/0558T 100219 100219
BONE/77078 080108 080108   ABPM/93784 070219 070219
BONE/77080 080108 080108
BONE/77081 080108 080108 |
BONE/76977 080108 080108
BONE/G0130 080108 080108
BEHV/G0473 010115 010115
HCAS/G0472 020515 020515

                PROCESS COMPLETED  ---   PLEASE CONTINUE
    PRESS PF3-EXIT  PF5-SCROLL BKWD  PF7-PREV PAGE  PF8-NEXT PAGE
```

The Medicare Beneficiary Identifier (MBI) Eligibility FROM and THRU Dates is being added to the Eligibility Detail Screen (MAP1751) in the DDE.

MAP1751 is accessed through option 01/10 Beneficiary/CWF.



```
MAP1751                  National Government Services, #13001      09/10/20

Kxt2938    SC            ELIGIBILITY DETAIL INQUIRY

MID                  CURR XREF HIC                PREV XREF HIC
TRANSFER HIC                    C-IND      LTR DAYS
LN                              FN           MI     SEX
DOB           DOD          ELIG FROM          ELIG THRU
ADDRESS: 1                                   2
         3                                   4
         5                                   6
       ZIP:

                          CURRENT ENTITLEMENT
PART A EFF DT         TERM DT         PART B EFF DT         TERM DT

CURRENT                 BENEFIT PERIOD DATA
FRST BILL DT          LST BILL DT         HSP FULL DAYS     HSP PART
DAYS
SNF FULL DAYS     SNF PART DAYS     INP DED REMAIN           BLD DED PNTS

                          PSYCHIATRIC
PSY DAYS REMAIN      PRE PHY DAYS USED      PSY DIS DT         INTRM DT
IND


PLEASE ENTER DATA - MID, LN, FN, SEX, DOB AND ELIG FROM/THRU.


Press PF3-EXIT   PF8-NEXT PAGE
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Reminder: Annual Mandatory Deadline for Submitting Low-Volume ESRD Facility Adjustment Requests for CY 2021 Are Due by 11/1/2020

Attention End-Stage Renal Dialysis Facilities

Per 42 CFR Section 413.232, CMS notified ESRD providers that November 1st of each year is now the mandatory deadline for the submission of low-volume attestations.

Thus, 11/1/2020 is the mandatory deadline for ESRD facilities to request continuation of their ESRD facility's low-volume exception or to request a new exception when the facility believes they are eligible to receive the low-volume payment adjustment for CY 2021.

To qualify for a low-volume adjustment to the facility's ESRD PPS rate the facility must have furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three years preceding the payment year. The three years preceding treatment data should be reflected on the last two settled cost reports and the most recent must be filed.

In addition, prior to 1/1/2016, the geographic proximity criterion is only applicable to ESRD facilities that are Medicare certified on or after 1/1/2011, to furnish outpatient maintenance dialysis treatments.

CR9478 instructs that effective 1/1/2016, CMS has:

1. Removed the grandfathering of ESRD facilities that were Medicare certified prior to 1/1/2011 and
2. Changed the geographic proximity criterion.

Specifically, (for the purposes of determining the number of treatments under the definition of a low-volume facility) beginning CY 2016, the number of treatments considered furnished by any ESRD facility (regardless of when it came into existence and was Medicare certified) will be equal to

- the aggregate number of treatments actually furnished by the ESRD facility and
- the number of treatments furnished by other ESRD facilities that are both
- under common ownership with the ESRD facility in question and
- five road miles or less from the ESRD facility in question.

If there is a change in ownership that does not result in a change in provider number but does cause a change in the original fiscal year to that of the new provider, resulting in two non-standard cost reporting periods, then the MAC should either:

- Combine the two non-standard cost reports that equals 12 consecutive months, or
- Where the two non-standard cost reporting periods in combination exceed 12 consecutive months, prorate the data to equal a full 12 consecutive month period.

In the situation where a hospital has multiple locations of a hospital-based ESRD facility under its governing body, the aggregate cost and treatment data of all of the locations (not just the treatment count of one of the sub-units or satellite entities) are reported on the hospital's cost report. In the case where a hospital has multiple locations reported on its cost report, the MAC may consider other supporting data in addition to the total treatments reported in each of the 12-consecutive month cost reports, including other supporting documentation which may include individual facility treatment counts, rather than the hospital's cost report alone. The hospital must provide the documentation to support the total treatment count for all the facilities that make up the total treatment count on the cost report for the MAC to review, even if not all the facilities are applying for the low-volume adjustment.

Requirements for Submission of the Low-Volume Request

The provider must notify National Government Services by **11/1/2020** if they believe they are eligible for the low-volume adjustment and include electronic documentation (prefer PDF) to support the request in accordance with basic low-volume criteria.

- Please do not send hard-copy mail.
- This documentation must include a signed attestation by provider official regarding no new, closed, or change of ownership situations (in prior three years) (PDF format).
- Providers should also include some form of documentation (internal provider statistical data, etc.) supporting less than 4,000 treatments in each of the prior three years (also in PDF, excel, or other electronic format). Please ensure that no PHI is sent via email.

Requests May Be Submitted Electronically to:

All requests for the low-volume adjustment should be submitted via NGS Connex or emailed to NGS via one of the following:

- Providers in the J6 MAC states of Illinois, Minnesota and Wisconsin should contact: mailto:Kim.Toloday@anthem.com
- Providers in the JK MAC states of Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont should contact: Jeff.Foster@anthem.com

When submitting email requests to designated NGS staff below, please include your RDF name and Medicare PTAN (legacy) number (e.g. 14-25XX, 33-23XX, 52-25XX, etc.) in the subject line of the email.

Related Content

- MLN Matters® MM7626: Recoupment of Incorrect Payments Made Under the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) for the Low-Volume Payment Adjustment
- MLN Matters® MM8898: Clarification of the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) Low Volume Adjustment
- End Stage Renal Disease (ESRD) Center ESRD on the CMS website (Monitor this site for posting of future resource materials.)

Issues With Medicare Beneficiary Submitted Claims – We Need Your Help

National Government Services has seen an increase of Medicare beneficiary submitted claims that often times result in a negative outcome. While most Medicare fee-for-service claims are submitted by a physician or practitioner, some Medicare beneficiaries find themselves in a situation where they must file their own Medicare claim. Please help your patients understand when an order and referral occurs to another provider they check to make sure they are enrolled in the Medicare Program and understand the role they play in filing claims.

Summary of Beneficiary Submitted Claims

A physician or practitioner who wants to treat and receive payment for services provided to a Medicare beneficiary should stay in compliance with Medicare law by enrolling in Medicare and filing claims on the beneficiary's behalf, or by opting out of Medicare and entering into a private contract with the beneficiary.

Providers can enroll in Medicare and choose to be either participating or nonparticipating. A provider that chooses to participate with Medicare agrees to always accept assignment for all Medicare-covered services. Providers that do not enter into a participation agreement with Medicare may choose on a claim-by-claim basis whether or not to accept assignment. If a nonparticipating physician does not accept assignment, then Medicare pays the beneficiary directly and the nonparticipating physician may bill the beneficiary up to the limiting charge amount.

A provider may also choose to opt out of Medicare (see Section 1802[b] of the Social Security Act [the Act]). Providers who properly opt out and maintain compliance with opt out requirement are excused from mandatory claim submission, assignment and limiting charge rules.

With the exception of those who have complied with opt-out procedures, when a physician or supplier furnishes a service that is covered by Medicare, and then attempts to charge and/or collect payment from the Medicare beneficiary, then the physician or supplier must submit a claim to Medicare. Physicians who violate the mandatory claim submission rules may receive a fine of up to $2,000 (see section 1848[g] [4] [B] of the Act).

Related Content

NGS Provider Outreach and Education

- Information for Physicians Who Refuse to Enroll, Opt-Out of the Medicare Program, or Submit Claims to Medicare

People with Medicare Education

- Find a Physician and Other Clinicians
- Find a State Health Insurance Assistance Program for Local Help
- Call Medicare at 1-800-MEDICARE for Help at (1-800-633-4227); 24 hours a day/7 days week

Code Set Update and New PC Print Version: October 2020

The PC Print October code set update will be available on our website 10/7/2020. The update contains the following enhancements:

CR 11708 contains the RARC and CARC published by the official ASC X12 website through July 2020.

CR 11709 is to implement operating rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC and RARC Rule - Update from CAQH CORE

A new PC Print V8.0 containing some fixes will be available 10/7/2020. Fixes include:

The COVERED, CONTRACT ADJ and NET REIM AMT fields were corrected on the Billing Type Summary Screen.

The Recent ANSI 835 File(s) feature was fixed.

DRG AMOUNTS field was corrected on the All Claims Screen.

To download the new PC Print V8.0 that contains the fixes, please uninstall your current version of PC Print. Then install the new PC Print V8.0 and then install PC Print October code set update, by accessing the NGS website, click on **Claims & Appeals** and then **EDI Solutions**. Once on the EDI Solutions landing page select **EDI Software: PC Print** and then Download PC Print.

Please take time on Wednesday 10/7/2020 to upgrade to the latest version of the software and October 2020 code set.

If you have any questions or need assistance in downloading the PC-Print software and code set update from the **EDI Solutions** section, please contact the EDI Help Desk:

- J6: 877-273-4334
- JK: 888-379-9132

Related Content

- MLN Matters® MM11708: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- MLN Matters® MM11709: Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE

National Government Services Provider Enrollment Appeals Mailbox Reminder

National Government Services, Inc. has seen an increase in submissions to the PE appeals mailbox (NGS-PE-Appeals@Anthem.com) that are not appropriate. The NGS PE appeals mailbox does not accept anything except enrollment related appeals and appeals development in relation to a provider enrollment request that has been denied or needed additional information.

Emails sent to the NGS provider enrollment appeal mailbox will be returned with directions on how they should be addressed for the following (not an all-inclusive listing):

- General enrollment questions
- Applications
- Participation agreement
- EFTs
- Questions about a submitted appeal (**Note:** the provider enrollment timeline is 90 days from receipt to render a decision); or,
- Development that is not for an appeal.

National Government Services Part B Medical Review Newsletter September 2020

National Government Services MR Department would like to welcome you to our newest service; a regular newsletter. It is our hope that you will find this newsletter helpful in providing you the resources you need to help you stay up-to-date on the MR activities performed here at NGS.

Our plan is to include:

- Educational Resources
- Updates and News
- Contact Information
- Reminders
- Helpful Tips

What's New?

Please note: TPE reviews continue to be on hold due to the PHE related to COVID-19. However, the NGS MR Department will be performing service specific post payment reviews for a random selection of claims billed to Medicare Part A and B.

Providers are encouraged to visit the Medical Review Focus Areas on our website. This dedicated area will identify which services are being selected, what documentation will be requested, and provide more details on these service specific post-payment reviews.

Note: If the link above does not take you directly to the MR focus area topic, it is often due to it being your initial visit to the NGS website. You may see a red box that requests a username and password. If this occurs, click on the link below the login boxes that says **Continue as a Guest**. It will then have you put in your Part B provider information. Once you do this and continue, you

will be prompted to verify you read a short attestation statement. After completing this information once, you should not have to do it a second time as long as you choose **Remember my choice** when putting in your provider information. Once you do this, click on the **Medical Policy & Review** tab near the top.

JK Part B

Service Specific Post Payment Review Announcements

JK MR will be conducting a service specific review of CPT codes A0425 and A0428 (Ambulance Transport).

In an effort to reduce the Part B CERT error rate, the MR Department will be conducting a service specific post payment review of the services mentioned. The primary focus of these audits will be to determine whether the medical necessity of the services billed is at the correct code per Medicare guidelines.

NGS has randomly selected claims billed for CPT A0425 and A0428 for post payment review in JK for Part B providers in the states of New York, Connecticut, Massachusetts, Rhode Island, Vermont, Maine and New Hampshire.

- **A0425 -** Ground mileage, per statue mile
- **A0428** - Ambulance service, basic life support, non-emergent transport (BLS)

NGS is also randomly selecting claims billed for CPT codes 11719, 11720 and 11721 for post payment review in JK for Part B providers in the states of New York, Connecticut, Massachusetts, Rhode Island, Vermont, Maine and New Hampshire.

- **11719** - Trimming of nondystrophic nails, any number
- **11720** - Debridement of nail(s) by any method(s) 1 to 5
- **11721** - Debridement of nails by any method(s) 6 or more

In addition to those services listed above, NGS will also randomly select claims billed for CPT codes 11055, 11056 and 11057 for post payment review in JK for Part B providers in the states of New York, Connecticut, Massachusetts, Rhode Island, Vermont, Maine and New Hampshire.

- **11055 -** Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion
- **11056 -** Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); 2 to 4 lesions
- **11057 -** Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); more than 4 lesions

J6 Part B

Service Specific Post Payment Review Announcements

J6 MR will be conducting a service specific review of CPT code 90837 (Psychotherapy, 60 minutes with patient).

In an effort to reduce the Part B CERT error rate, the MR Department will be conducting a service specific post payment review of the services mentioned. The primary focus of these audits will be to determine whether the medical necessity of the services billed is at the correct code per Medicare guidelines.

NGS has randomly selected claims billed for CPT 90837 for post payment review in J6 for Part B providers in the states of Illinois, Minnesota and Wisconsin.

- **90837** - Psychotherapy, 60 minutes with patient

NGS will also randomly select claims billed for CPT A0425-A0428 for post payment review in J6 for Part B providers in the states of Illinois, Minnesota and Wisconsin.

- **A0425 -** Ground mileage, per statue mile
- **A0426 -** Ambulance service, advanced life support, non-emergency transport (ALS)
- **A0428 -** Ambulance service, basic life support, non-emergent transport (BLS)

If a claim is selected for review, the provider will receive an ADR letter. Providers with claims selected for review must submit the requested documentation within 45 days of the date of the ADR letter. Failure to submit the requested documentation in a timely manner may result in a denial of the billed services.

Visit our website for more details and educational resources relating to these review topics.

Provider Tips

- NGS recommends responding to ADRs within 35–40 days of letter date (CMS allows providers 45 days of the ADR date). See the ADR Timeline Calculator available on our website for help with determining the target date that the requested medical records must be received by NGS.
- Be sure to **forward the requested documentation** to the preferred method of submission.
- **If you are mail in your ADR, please send each response separately** and attach a copy of the corresponding ADR. It is acceptable to send multiple responses in a single mailing; however**, each response must be individually bundled with a copy of the corresponding ADR** within the mailing to facilitate proper handling and review of the ADR response.
- Include **all records necessary to support the services** for the dates requested.
- Do not include additional correspondence with documentation submissions. **Unrelated correspondence should be mailed separately**.
- Records must be complete and legible. Be sure to **include both sides** of double-sided documents.
- The NGS self-service portal, NGSConnex, allows both Part A (including home health, hospice and FQHCs) and Part B providers to respond to ADRs electronically with no need to mail or fax a response to complete the ADR process. Further details are available on our website. If you are a current user of NGSConnex, click on the link for the NGSConnex User Guide for step-by-step instructions on how to submit ADR. If you are not a current user, sign up and get started!
- All services must **include necessary signatures and credentials** of professionals. See the CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3, Section 3.3.2.4, "Signature Requirements".
- Visit the Medical Review Focus Areas on the NGS website for educational resources relating to these services being reviewed.

Contact Us

If you have received an ADR letter relating to these reviews and have questions, you may contact the MR department at the following email address

States	Email Address
Connecticut, Maine, Massachusetts, New Hampshire, New York, Vermont, Rhode Island	JKBcasemanagement@anthem.com
Illinois, Minnesota, Wisconsin	J6Bcasemanagement@anthem.com

Proper Billing for Opioid Treatment Program Weekly Bundles for HCPCS Codes G2067-G2075

Medicare introduced the OTP as a covered Part B benefit beginning with dates of service on and after 1/1/2020. Payment is made to Medicare-enrolled OTP providers as a weekly bundle that includes counseling and therapy, intake, patient assessments and MAT.

We recently identified billing inconsistencies on OTP claims, therefore, we are sharing proper billing criteria with all of our OTP providers. The purpose of this educational article is to ensure our Medicare-enrolled OTP providers are properly submitting claims and being paid accordingly. This article addresses billing for the weekly bundles (MAT and non-MAT).

Please be aware that claims processing edits will reject OTP claims that are not consistent with the billing criteria below. Once rejected, you will need to make the necessary billing corrections and submit a new claim.

- Date of Service = the first date of care for that week. Do not span “From” and “To” dates. Do not cross months on one claim
- Place of Service = 58
- Units of service = 1 (HCPCS description includes seven days)
- Billed amount = Geographically Adjusted Fee from Locality Adjusted Rates
- Each week must be billed on a separate line item

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
08	03	20	08	03	20	58		G2067		1	21799	001		NPI	
08	10	20	08	10	20	58		G2067		1	21799	001		NPI	
08	17	20	08	17	20	58		G2067		1	21799	001		NPI	
08	31	20	08	31	20	58		G2067		1	21799	001		NPI	

Please review Opioid Treatment Add-on Code G2078 and G2079 for MUE Values for instructions on billing these add-on codes for take home medication.

Please view the MLN Opioid Treatment Programs Medicare Billing and Payment Fact Sheet for additional information.

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filing claims on the beneficiary's behalf, or by opting out of Medicare and entering into a private contract with the beneficiary.

Providers can enroll in Medicare and choose to be either participating or nonparticipating. A provider that chooses to participate with Medicare agrees to always accept assignment for all Medicare-covered services. Providers that do not enter into a participation agreement with Medicare may choose on a claim-by-claim basis whether or not to accept assignment. If a nonparticipating physician does not accept assignment, then Medicare pays the beneficiary directly and the nonparticipating physician may bill the beneficiary up to the limiting charge amount.

A provider may also choose to opt out of Medicare (see Section 1802[b] of the Social Security Act [the Act]). Providers who properly opt out and maintain compliance with opt out requirement are excused from mandatory claim submission, assignment and limiting charge rules.

With the exception of those who have complied with opt-out procedures, when a physician or supplier furnishes a service that is covered by Medicare, and then attempts to charge and/or collect payment from the Medicare beneficiary, then the physician or supplier must submit a claim to Medicare. Physicians who violate the mandatory claim submission rules may receive a fine of up to $2,000 (see section 1848[g] [4] [B] of the Act).

Related Content

NGS Provider Outreach and Education

- Information for Physicians Who Refuse to Enroll, Opt-Out of the Medicare Program, or Submit Claims to Medicare
- Opt-Out and Private Contracting

People with Medicare Education

- Find a Physician and Other Clinicians
- Find a State Health Insurance Assistance Program for Local Help
- Call Medicare at 1-800-MEDICARE for Help at (1-800-633-4227); 24 hours a day/7 days week

Fee Schedule Adjustments Reminder for 99441-99443

National Government Services has received several inquiries from providers regarding the adjustment of CPT codes 99441-99443. When CMS announced that they were changing the fee schedule allowance for these procedures to mirror codes 99212-99214, they also announced that MACs would be adjusting previously submitted claims to allow the codes billed at a higher allowance.

It is important to remember that NGS processes claims using the Medicare Part B Physician Fee Schedule. The allowance for related claims will be **the lower** of the published fee schedule rate and the submitted amount for that service. Therefore, if the submitted charge for codes 99441-99443 was lower than the fee schedule amount, the claim will not be allowed at the adjusted fee schedule. Services will never allow greater than the charge submitted by a provider.

If you have charges for codes 99441-99443 that were not adjusted to equal the new allowance indicated by CMS, please check the submitted amount for the service. If the submitted amount is not accurate and needs to be corrected, then you may do so via the reopening process.

Related Content

- Levels of Appeals and Time Limits for Filing
- Reopening versus Redetermination

National Government Services – Articles for Part A and Part B Providers

Award of MAC Contract for Jurisdiction 6

The CMS selected National Government Services to retain the J6 MAC Contract. As a result, there will be no changes to your service or the support we provide you. NGS looks forward to continuing to serve you.

Please go to the CMS web page Who are the MACs: A/B MAC Jurisdiction 6 (J6) for more details.

Benefits of Using Electronic Data Interchange Transactions

There are a number of advantages to enrolling and submitting claims online. Claims and other transactions submitted electronically process considerably faster than paper submission. For example, HIPAA-compliant **electronic claims** are held in the payment floor for **14 days** whereas **paper claims** are held in the payment floor for **29 days.**

Not only do the claims process and complete faster, but the claims are received much faster. With EDI submission you do not have to worry about the postal service and the amount of time it takes for your claims to reach us after you send them. With electronic claim submission, once you or your electronic vendor send the claims, we receive them after the next daily cycle.

Some of the other advantages of electronic submission include:

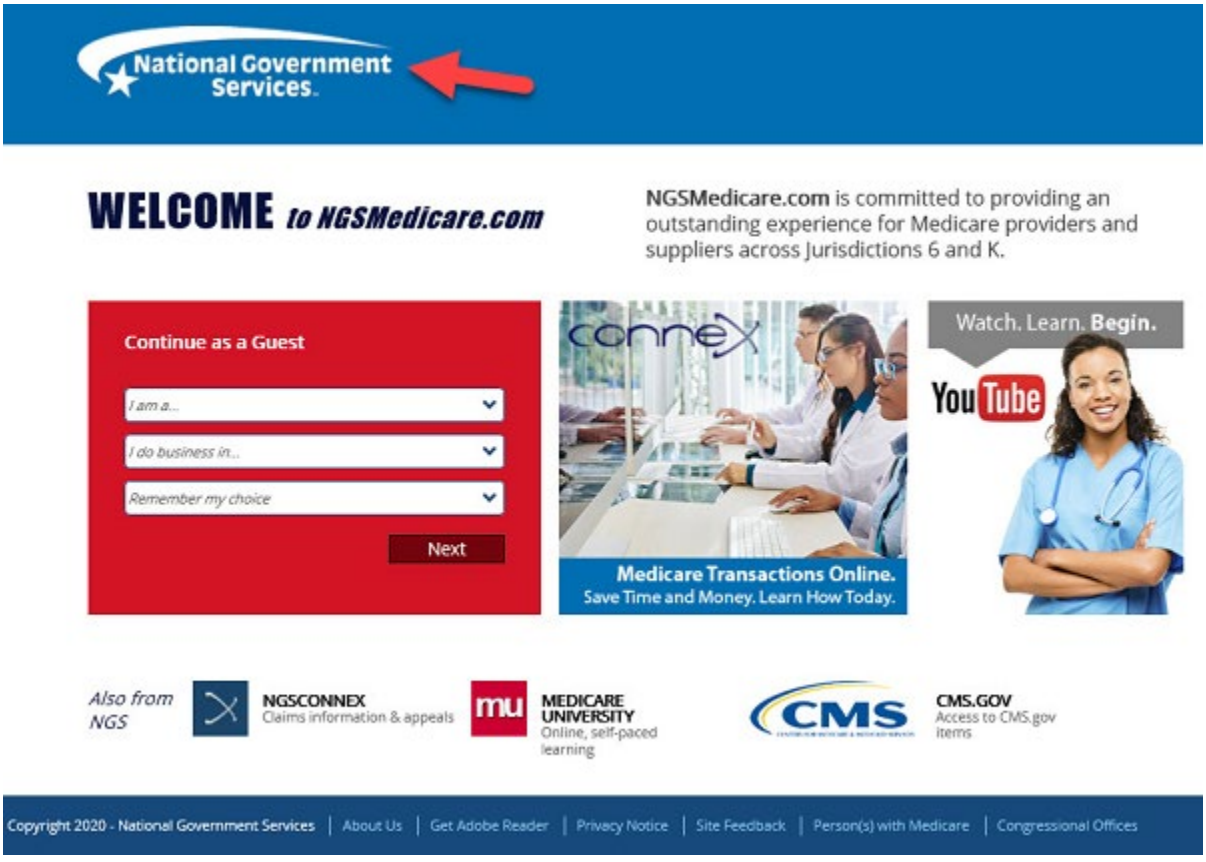
- **Increased cash flow** and lower administrative costs
- **Ease of billing**

- **No paper claims to complete**
- **Added efficiency** and accurate claims filing
- **Posting of payments** process easier from electronic file
- **Specific EDI** email inquiry form
- **EDI Helpdesk** for electronic claim questions

Using EDI to submit your claims to Medicare will allow you to input your claim data one time. That data is then submitted to Medicare (and other payers) quickly and easily and claim determinations are received sooner and easier. EDI is the quicker, easier and less burdensome path to help your office flow. For additional information related to EDI services, you can review the NGS EDI Solutions web page.

Changing Your Line of Business on NGSMedicare.com

To change your line of business when visiting our website, simply click on our National Government Services logo located on the upper left hand side of any page. Clicking on the NGS logo will return this welcome page where you may select your line of business and state. If you prefer to return to the same line of business on your next visit, select “Remember my choice.”



CMS-855B COMPLETION TIPS FOR CLINICS/GROUP PRACTICES AND SUPPLIERS REVALIDATION APPLICATION

Follow the instructions printed on the CMS-855B application and refer to this list of sections required for revalidation.

Section Required for Revalidation	General Guidelines
Section 1: Basic Information	1A – Select 'You are Revalidating your Medicare enrollment'
Section 2: Identifying Information	2A – Specify the type of supplier the specialty cannot be "Other" for revalidation 2B1 – Complete all fields that apply The legal business name reported must match the NPPES Registry and the IRS document **exactly**, including any suffix, i.e., PC, PA, LLC, etc. Specify the EIN/TIN 2B2 – Specify any state licenses and/or certifications that apply for the clinic/group 2B3 – Enter the clinic/group's correspondence address and telephone number Must be where the entity in 2B1 can be reached directly May not report a billing agency's address/phone number 2C – Complete only if a hospital 2D – Enter any comments/special circumstances that apply 2E – Complete only if a physical therapy or occupational therapy group 2F – Complete only if an ambulatory surgical center (ASC) 2H – Complete only if a group will bill for ADI services
Section 3: Adverse Legal Action/Convictions	Section must be answered and only a "yes" or "no" response is acceptable • If there are no final adverse legal actions, convictions, exclusions, revocations, or suspensions, be sure to check the box labeled 'No' • If there are any actions whether under the current or a former name or business identity, check the box labeled 'Yes' and list details and attach final adverse legal action documentation and/or resolutions

Section Required for Revalidation	General Guidelines
Section 4: Practice Location Information	Copy appropriate page in each section as many times as necessary 4A – Complete this section for each practice location where the clinic/group will render services • this includes every office, clinic, hospital, assisted living community, skilled nursing facility (SNF) or any other health facility where the clinic/group will be rendering services • list every NPI/PTAN for each practice location (Do not report group member NPI/PTANs reassigned to the clinic/group) 4B – Enter special payment address (pay to address) 4C – Enter medical records location(s) if different than 4A or 4E 4D – Complete if rendering services in patients' homes 4E–4G – Complete these sections if a mobile or portable supplier
Section 5: Ownership Interest and/or Managing Control Information (Organizations)	Copy appropriate page as many times as necessary 5A–5B – Complete these sections for each **organization** that has ownership interest or managing control • for each section 5A, complete a corresponding section 5B

Section 6: Ownership Interest and/or Managing Control Information (Individuals)	Copy appropriate page in each section as many times as necessary
	
	6A–6B – Complete these sections for **every individual** with ownership interest or managing control (i.e. manager, owner, board of trustees or other governing body, and authorized or delegated official)
	• Authorized official – at least one authorized official must be designated and reported.
	  ○ To report an authorized official, must select 'Authorized Official' **and** an additional box indicating '5 Percent or Greater Direct/Indirect Owner', 'Partner' and/or a 'Director/Officer'
	  ○ may also select Managing Employee
	• Managing Employee – at least one Managing Employee must be designated and reported
	• Delegated official
	  ○ To report a delegated official, must select 'Delegated Official' **and** an additional box specifying an additional relationship
	  ○ Cannot be a Contracted Managing Employee
	• All individuals currently on file need to be specified during revalidation or they will be end dated
	• For each section 6A, complete a corresponding section 6B

Section 8: Billing Agency Information	• Complete with billing agency information **or** select the box indicating that this does not apply
Section 13: Contact Information	Copy appropriate page as many times as necessary • Complete with the contact person's information
Section 15: Certification Statement	**Note:** For revalidation, only one current authorized **or** delegated official signature and date is needed 15B and 15C – New authorized official added in section 6, signature and date is required
Section 16: Delegated Official	16A and 16B – New delegated official added in section 6, signature and date is required, must be cosigned and dated by an authorized official

Section Required for Revalidation	General Guidelines
Section 17: Supporting Documentation	Contains a list of supporting documentation • Remember to include the form CMS-588 (EFT) version (01/17) **and** a confirmation of account information on bank letterhead **or** a voided check • Supporting Documentation Required for Enrollment Revalidations

CMS-855R Version (1/20) Reassignment of Medicare Benefits

As a reminder, effective 5/1/2020, the CMS-855R Version (1/20) is the only version of the CMS-855R that can be submitted to allow a provider to reassign benefits to an organization/group or individual practitioner or to terminate a reassignment from an organization/group or individual practitioner.

- **Section 2** on the new form is to be completed with the information of the **billing entity** for the rendering provider which can be **either** A. Organization/Group Identification **or** B. Individual Practitioner Identification.
- **Section 3** should be completed with information for the **Individual Practitioner Who is Reassigning Benefits** to either the organization/group or the individual practitioner identified in Section 2.

Please refer to the Job Aid CMS-855R (01/20) Reassignment of Medicare Benefits Completion Tips for Physicians and NPPs that Reassign Some or All Benefits as a reference.

EDI Monthly Bulletin for September 2020

How to Resolve the Part A and B Edits for NPI Issues

Listed below are two Part A and two Part B edits that are hitting the Top 10 Quarterly Edits list. These are edits that are rejecting claims for National Provider Identifier (NPI) issues. Please review the Edit, Description and How to Correct/Avoid columns for further information.

Part A

Table Header (25% gray)	Description	How to Correct/Avoid
X223.084.2010AA.NM109.050	**A8:496:85:** The billing provider's NPI is not associated with the Trading Partner ID number. The Trading Partner ID is not authorized to submit claims for the provider. **LOGIC:** 2010AA.NM109 billing provider must be "associated" to the Trading Partner (from a trading partner management perspective) in 1000A.NM109.	The provider must be enrolled with electronic data interchange (EDI) for claims submission by this Trading Partner.
X223.319.2310A.NM109.010	**A7: 562:71**: Attending provider reference ID must be a valid NPI. **LOGIC:** 2310A.NM109 must be valid according to the NPI algorithm.	Verify the provider's NPI is on the Medicare Crosswalk.

Part B

Edit	Description	How to Correct/Avoid
X222.087.2010AA.NM109.050	**A8:496:85:** The billing provider's NPI is not associated with the Trading Partner ID number. The Trading Partner ID is not authorized to submit claims for the provider. **LOGIC:** 2010AA.NM109 billing provider must be "associated" to the Trading Partner (from a trading partner management perspective) in 1000A.NM109.	Verify the billing provider's NPI is registered with the Trading Partner ID prior to submitting claims.
X222.262.2310B.NM109.030	**A7:562:82:** Rendering provider ID must be a valid NPI. **LOGIC:** 2310B.NM109 must be a valid NPI on the Crosswalk when evaluated with 1000B.NM109, except when 2300.REF with REF01 = P4 and REF02 = 82.	Verify the rendering provider NPI matches what is registered in PECOS.

Flu and Pneumonia Shots: Extra Push This Fall and Spring

National Government Services supports the CMS and NIAM recent announcements to make strong recommendations for Medicare patients to get their flu/pneumonia shots and refer Medicare patients to other vaccine providers, if necessary. Here are some key messages and resources to help our Medicare beneficiaries get flu and pneumonia shots that can be shared with others in your facilities, groups and clinics. More flu and pneumonia information will be forthcoming over the next several months.

Key Messages

- Ensure Medicare patients remain current with flu, pneumonia and other vaccinations. During the public health emergency, this is especially important for those with chronic diseases.
- Make sure a high-dose flu vaccine is given to people 65 and older.
- Remind Medicare patients that they may be eligible for the pneumonia booster.
- A flu and/or pneumonia shot can be given at the doctor's office, local health department, local retail pharmacy or clinic with or without an appointment; drive-thru might be an option; please check local listings.

NGS and Other Related Content

- CDC Older Adult Resource Materials (posters, flyers to post at offices and websites)
- Flu Shots Information for Medicare patients
- Influenza Virus Vaccine and Administration
- How Nurses and Medical Assistants Can Foster a Culture of Immunization in the Practice
- Pneumococcal Shots Information for Medicare patients
- Pneumococcal Vaccine and Administration

Flu Season 2020-2021 Has Arrived

The 2020-2021 flu season began on 8/1/2020.

The Medicare flu billing codes and fees along with the brand name and manufacturer are located on the CMS Seasonal Influenza Vaccines Pricing web page.

Please note: The NDCs change each influenza season. The NDC must be included in Loop 2410 LIN segments of the electronic claim (Item 19 on the CMS-1500 paper claim). Each box of vaccine includes the NDC assigned by the manufacturer. The correct NDC and HCPCS code for the influenza vaccine must be billed in order for your claim to process, incorrectly billed claims will be denied.

The administration code for the influenza vaccine is G0008 and is not subject to the Medicare deductible or coinsurance. Billing codes 90471 or 90472 will result in claim denial.

Please review and use the appropriate flu vaccine code to avoid processing delays and claim denials.

Payment Allowances and Effective Dates for the 2020-2021 Flu Season

Code	Labeler Name	Vaccine Name	Payment Allowance	Effective Dates
90653	Seqirus	Fluad (2020/2021	$59.529	8/5/2020 – 7/31/2021
90694	Seqirus	Fluad Quadrivalent (2020/2021)	$61.000	8/5/2020 – 7/31/2021
90662	Sanofi Pasteur	Fluzone High-Dose Quadrivalent (2020/2021)	$ 60.982	8/5/2020 – 7/31/2021
90672	MedImmune	FluMist Quadrivalent (2020/2021)	$26.876	8/12/2020 – 7/31/2021
90674	Seqirus	Flucelvax Quadrivalent (2020/2021) (Pres Free)	$29.228	8/12/2020 – 7/31/2021
90682	Sanofi Pasteur	Flublok Quadrivalent (2020/2021)	$60.982	8/1/2020 – 7/31/2021

Code	Labeler Name	Vaccine Name	Payment Allowance	Effective Dates
90685	Sanofi Pasteur Seqirus	Fluzone Quadrivalent 0.25ml (2020/2021) (Pres Free) Afluria Quadrivalent 0.25ml (2020/2021) (Pres Free)	$21.129	8/1/2020 – 7/31/2021
90686	GlaxoSmithKline Sanofi Pasteur Seqirus	Fluarix Quadrivalent (2020/2021) (Pres Free) Flulaval Quadrivalent (2020/2021) (Pres Free) Fluzone Quadrivalent (2020/2021) (Pres Free) Afluria Quadrivalent (2020/2021) (Pres Free)	$19.581	8/1/2020 – 7/31/2021
90687	Sanofi Pasteur Seqirus	Fluzone Quadrivalent 0.25ml (2020/2021) Afluria Quadrivalent 0.25ml (2020/2021)	$9.584	8/1/2020 – 7/31/2021
90688	Sanofi Pasteur Seqirus	Fluzone Quadrivalent (2020/2021) Afluria Quadrivalent (2020/2021)	$19.168	8/1/2020 – 7/31/2021
90756	Seqirus	Flucelvax Quadrivalent (2020/2021)	$27.695	8/12/2020 – 7/31/2021

How to Find a Local Coverage Determination

As the MAC for J6 and JK, NGS is responsible for posting and maintaining LCDs and articles for many Medicare billed services. These LCDs and articles can be found at the Medical Policy Center.

Please Note: There are many procedures for which NGS does not have an LCD or article.

If you do not find a coverage document on a procedure in our Medical Policy Center, then it may not have a local determination. Title XVIII of the Social Security Act section 1862 (a) (1) (A) applies to all billed services, i.e., coverage and payment of those services must be considered to be medically reasonable and necessary.

An LCD is a determination by the MAC that defines coverage criteria for a particular service within its jurisdiction. The LCD consists of indications and limitations of coverage. The related billing and coding article includes CPT/HCPCS codes, ICD-10 codes and documentation guidelines that support the LCD.

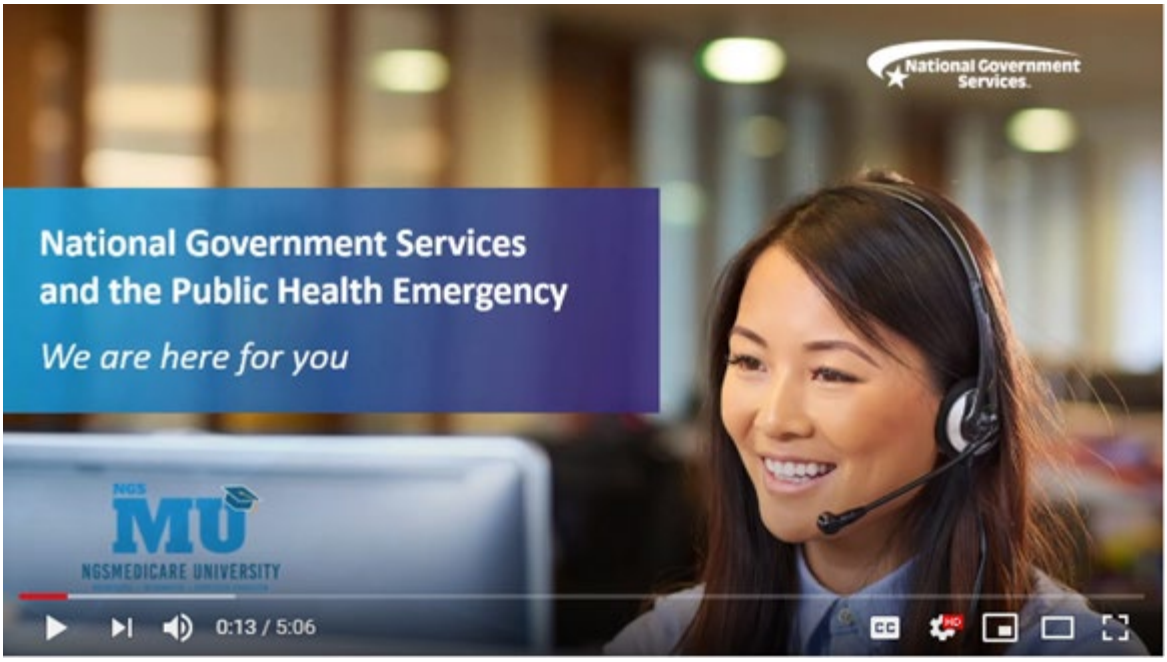
Each LCD and article listing in our index includes the CPT/HCPCS codes that are covered by these documents.

Medical Policy Center Example

LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Autonomic Function Testing *Related terms: tilt table, sudomotor*	L36236	A57024	A54403	95921, 95922, 95923, 95924, 95943
Biomarker Testing (Prior to Initial Biopsy) for Prostate Cancer Diagnosis *Related terms: N/A*	L37733	A56609	A56742	81539, 84153, 84154, 86316, 81479, 0005U

National Government Services and the Public Health Emergency

The health and well-being of our beneficiaries, providers, associates and communities is our top priority. We understand the uncertainty and concerns you may be experiencing during this public health emergency and want to assure you that we are committed to the needs of our partners and associates as situations evolve. Watch this five-minute video to learn about how National Government Services has taken steps to ensure we continue to provide exceptional service to you during this public health emergency:



National Government Services Proposed LCDs for Comment

The proposed LCDs listed below are being presented for comment for the Jurisdiction 6 and Jurisdiction K MACs. The formal comment period extends from 9/24/2020 – 11/7/2020.

These draft LCDs will be presented at the NGS LCD Open Meeting (open to the public) held by teleconference/webinar on 10/15/2020.

For all details of phone/webinar access, please access the link above.

Comments on the draft LCDs can be submitted to the address listed at the end the *Proposed/Draft Process Information* section of the LCD. Each LCD also has a Billing and Coding article attached as a link at the end of the LCD. Comments must be accompanied by a Conflict of Interest Disclosure.

Proposed LCDs:

- Colon Capsule Endoscopy (CCE)
- Facet Joint Interventions for Pain Management
- Heavy Metal Testing
- Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Tremor
- Select Minimally Invasive GERD Procedures

October 2020 EDI Front-End Quarterly Release

Please be advised that while the CMS-mandated quarterly release for October 2020 will be installed the weekend of 10/4/2020, the code set updates included with this release will not be effective in the EDI Front-End processing system until Wednesday, 10/7/2020. **EDI claims sent prior to 10/7/2020 that include any of the new or updated codes will reject in the EDI front-end.**

Title and Description	Purpose	Trading Partner Impact
CR11708 (CARC/RARCs CR) MLN Matters® MM11708 Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update	This CR instructs Medicare system maintainers to update MREP and PC Print with the CARC and RARC updates as posted on the official ASC X12 website on or about 7/1/2020.	Trading Partners should review the MedLearn Matters article for this CR so that they are aware of the modifications that have been made to MREP and PC Print software to reflect the 7/1/2020 CARC and RARC changes. There is a new MREP Codes.ini file, which will be available for download from the CMS website. There are new PC Print code set updates, which may be downloaded from our website under the Claims & Appeals tab > Electronic Data Interchange > Electronic Data Interchange Software link
CR11709 (CAQH CORE CR) MLN Matters® MM11709 Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE	This CR instructs the contractors and SSMs to update systems based on the CORE 360 Uniform Use of CARC and RARC Rule publication. These system updates are based on the CORE Code Combination List to be published on or about 6/1/2020. The codes and associated messages are updated to in the updated versions of MREP and PC Print software.	Trading Partners should review the MedLearn Matters article for this CR so they are aware of the Business Scenario combinations and RARC/CARC updates to the PC PRINT and MREP software. There is a new MREP Codes.ini file, which will be available for download from the CMS website. There are new PC Print code set updates, which may be downloaded from our website under the Claims & Appeals tab > EDI Solutions > EDI Software: PC Print > Download PC Print

October 2020 Release "Dark Days" for the Common Working File Hosts

For the upcoming October 2020 Release:

- For Production, CWF will be observing dark days starting Friday, 10/2/2020 through Sunday, 10/4/2020 to accommodate the anticipated duration of this activity and to ensure the completion of weekly/monthly/quarterly processing and the installation of the October 2020 Release.

These dark days will limit access to information provided by the IVR system and to our self-service portal, NGSConnex. Providers may experience limited or no access to claims, eligibility,

claim overlap, patient status, check inquiry, reopening/redetermination status, offset information and financial claim information.

Providers' Obligation to Report and Refund Medicare Overpayments with Appropriate Forms

Healthcare providers have an obligation to report and refund federal program overpayments and continue to do so, but National Government Services would like to remind how providers shall report Medicare Part B Overpayments, so that refunds are posted appropriately.

This article clarifies that providers shall use applicable NGS forms when sending any refunds of any kind. The key to reporting and repaying overpayments in compliance with Medicare policies is selecting the appropriate form and submitting it to the correct address for processing.

- If you are practicing in our J6 area, which consist of Illinois, Minnesota and Wisconsin, providers shall use the following overpayment refunds forms:
    - J6 Part B Overpayment Recovery Unit Voluntary Refund Form
    - J6 Medicare Secondary Payer Part B Voluntary Refund Form
- If you are practicing in our JK area, which consist of Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont, providers shall use the following overpayment refunds forms:
    - JK Part B Overpayment Recovery Unit Voluntary Refund Form
    - JK Medicare Secondary Payer Part B Voluntary Refund Form

Important Reminders

1. Complete the form in its entirety as missing information will delay processing.
2. Be sure the form is mailed to the appropriate address listed at the bottom of the form.
3. Include any additional documentation that would enable processing of the request.

Related Content

- NGS Overpayment webpage

Updated Future Effective LCD and Article

Fluid Jet System Treatment for LUTS/BPH (L38367)

The Fluid Jet System Treatment for LUTS/BPH is now considered medically reasonable and necessary for 30-150 cc- sized prostates when the Indications of Coverage have been met, effective for services rendered on or after 11/1/2020.

References have been added to the Bibliography and an updated Response to Comments article has been attached to the LCD, effective for services rendered on or after 11/1/2020.

The Notice period is 9/17/2020 through 10/31/2020.

Billing and Coding: Fluid Jet System Treatment for LUTS/BPH (A56797)

The Fluid Jet System treatment for LUTS/BPH is now considered medically reasonable and necessary for 30-150 cc- sized prostates when the Indications of Coverage have been met in LCD L38367. HCPCS code C2596 has been added for Part A and Ambulatory Surgical Center billing, effective for services rendered on or after 11/1/2020.

We Can Now Accept Electronic Appeal Requests Using the X12 275 Version 6020 Transaction

National Government Services will now allow Medicare Part A and Part B providers to submit their claim appeal requests, including medical record documentation, through electronic transactions rather than a paper appeal form.

The purpose of the appeals process is to ensure the correct adjudication of previously processed claims. The appeal can take the form of a **reopening -** a reprocessing of a claim to fix minor mistakes, or a **redetermination** - an examination of a claim that includes analysis of documentation. To learn more about the appeals process visit About Appeals on our website.

Providers can now use the 275 electronic transaction to request a first level appeal which may include additional documentation. When a provider is requesting an appeal using the 275 transaction it is required to include:

- The value of 15 in BGN01
- The request for the appeal using:
    - Completed Level 1 Redetermination Request Form
        - Part A Redetermination Request Form
        - Part B Redetermination Request Form

OR

- Letter that includes the following:
    - Beneficiary name
    - Medicare number/MBI
    - Specific service/items for which the appeal is being requested
    - Specific dates of service
    - Name of the party or representative of the party (the provider)

Providers already enrolled to send the 275 transaction as unsolicited documentation to support the claim or as a solicited response to a request for documentation, will NOT have to enroll to send electronic appeals. The 275 enrollment includes sending documentation to support the claim and the first level appeal request.

We support up to ten separate documents sent in the 275 for one claim (up to ten iterations of the LX loop within each ST/SE).

For additional information on the 275 transaction see the NGS 275/HL7 Claim Attachment Companion guide located in the EDI Solutions section of our website.

Next Steps: You will need to contact your software vendor, system maintainer or clearinghouse to determine the process for your practice management/claim submission software.

We are excited to be able to offer this next level of automation to our provider community.

Related Content

- Standard Companion Guides
- Levels of Appeals and Time Limits for Filing
- Reopening versus Redetermination

CODE SET UPDATE AND NEW PC PRINT VERSION: OCTOBER 2020

The PC Print October code set update will be available on our website 10/7/2020. The update contains the following enhancements:

- CR 11708 contains the RARC and CARC published by the official ASC X12 website through July 2020.
- CR 11709 is to implement operating rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC and RARC Rule - Update from CAQH CORE

A new PC Print V8.0 containing some fixes will be available 10/7/2020. Fixes include:

- The COVERED, CONTRACT ADJ and NET REIM AMT fields were corrected on the Billing Type Summary Screen.
- The Recent ANSI 835 File(s) feature was fixed.
- DRG AMOUNTS field was corrected on the All Claims Screen.

To download the new PC Print V8.0 that contains the fixes, please uninstall your current version of PC Print. Then install the new PC Print V8.0 and then install PC Print October code set update, by accessing the NGS website, click on **Claims & Appeals** and then **EDI Solutions**. Once on the EDI Solutions landing page select **EDI Software: PC Print** and then Download PC Print.

Please take time on Wednesday 10/7/2020 to upgrade to the latest version of the software and October 2020 code set.

If you have any questions or need assistance in downloading the PC-Print software and code set update from the **EDI Solutions** section, please contact the EDI Help Desk:

- J6: 877-273-4334
- JK: 888-379-9132

Related Content

- MLN Matters® MM11708: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- MLN Matters® MM11709: Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE

NEW VERSION OF PC-ACE: OCTOBER 2020

PC-ACE Version 4.8 contains several CMS mandates and product enhancements including, but not limited to, the items listed below.

- CR11081 - Home Health (HH) Patient-Driven Groupings Model (PDGM) - Split Implementation
- CR11623 - Update to the International Classification of Diseases, Tenth Revision (ICD-10) Diagnosis Codes for Vaping Related Disorder and Diagnosis and Procedure Codes for the 2019 Novel Coronavirus (COVID-19)

- CR11814 - July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- CR11896 - Primary Care First (PCF) and Serious Illness Patient (SIP) Models: Part 2: FFS Payments and other claims-based adjustments
- CR11937 - Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
- CR11944 - October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3
- CR11835 - Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
- CR11836 - New Point of Origin Code for Transfer from a Designated Disaster Alternate Care Site
- CR11880 - Billing for Home Infusion Therapy Services On or After January 1, 2021
- CR11881 - Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE

To download PC-ACE, please access our website, click on **Claims & Appeals** and then **EDI Solutions**. Once on the EDI Solutions landing page, select **EDI Software: PC-ACE** and then **Download PC-ACE**.

Please take time on Wednesday, 10/7/2020, to upgrade to the latest version (4.8) of the software.

If you have any questions or need assistance in downloading the PC-ACE upgrade from the **EDI Solutions** section, please contact the EDI Help Desk:

- J6: 877-273-4334
- JK: 888-379-9132

LCD and Article Updates for October 2020

LCD Revisions:

Transcranial Magnetic Stimulation (L33398)

The notice period was extended to end on 9/30/2020 and the Revision Effective date has been changed from 8/1/2020 to 10/1/2020.

Billing and Coding Article Updates:

Billing and Coding: Bevacizumab and biosimilars (A52370)

Based on the annual ICD-10 code update, ICD-10 code G96.8 has been deleted in Group 1 and replaced with G96.89.

Billing and Coding: Cardiac Catheterization and Coronary Angiography (A52850)

Based on the annual ICD-10 updates for 2021, ICD-10 code G11.1 was deleted and is replaced by G11.11 in Groups 1 and 2 covered diagnoses. In addition, to clarify coding, the ICD-10 section has been revised to remove the requirement for multiple ICD-10 groups for specified CPT codes, and Group 3 has been revised to remove CPT codes 93458, 93459, 93460 and 93461.

Billing and Coding: Computed Tomographic (CT) Colonography for Diagnostic Uses (A57026)

Due to the annual ICD-10 updates, K59.8 has been deleted, and new codes K59.81 and K59.89 have been added effective 10/01/2020.

Billing and Coding: Corneal Pachymetry (A56548)

Due to the annual ICD-10-CM update, ICD-10-CM code, H18.51, was deleted from the “ICD-10-CM Codes That Support Medical Necessity” section and replaced by ICD-10-CM codes H18.511, H18.512, H18.513 – Group 1.

ICD-10-CM codes, H18.501; H18.502, H18.503, H18.521, H18.522, H18.523, H18.531, H18.532, H18.533, H18.541, H18,542, H18.543, H18.551, H18.552, H18.553, H18.591, H18.592, H18.593, T86.8481, T86.8482, T86.8483, T86. 8491, T86.8492, T86.8493 were added to the “ICD-10-CM Codes That Support Medical Necessity” section - Group 1

ICD-10-CM code H18.59, was deleted - Group 1

ICD-10-CM code T86.840 was deleted from the “ICD-10-CM Codes That Support Medical Necessity” section and replaced by ICD-10-CM codes T86.8401, T86.8402, T86.8403 – Group 1

ICD-10-CM code T86.841 was deleted from the “ICD-10-CM Codes That Support Medical Necessity” section and replaced by ICD-10-CM codes T86.8411, T86.8412, T86.8413– Group 1

Billing and Coding: Denosumab (Prolia ™, Xgeva ™)(A52399)

Based on the annual ICD-10 code update, the following ICD-10 codes (M80.0AXA, M80.0AXD, M80.0AXG, M80.0AXK, M80.0AXP and M80.0AXS) have been added to ICD-10 code range M80.00XA - M80.88XS in Groups 2, 3, 5 and 8. The following ICD-10 codes (M80.8AXA,

M80.8AXD, M80.8AXG, M80.8AXK, M80.8AXP and M80.8AXS) have been added to Groups 2, 3, 5 and 8. In Group 4, ICD-10 code N18.3 has been deleted and replaced with N18.30, N18.31 and N18.32. The descriptor for ICD-10 code Z88.8 was changed in Group 4.

Billing and Coding: EEG – Ambulatory Monitoring (A57030)

Due to annual ICD-10 updates, the following codes have been added to Group 1 in the ICD-10 Codes that Support Medical Necessity section: G40.42, G40.833, G40.834.

Billing and Coding: Heavy Metal Testing (A56767)

Based on the annual ICD-10 updates for 2021, G11.1 was deleted from ICD-10 Codes that Support Medical Necessity, Group 13 and replaced by G11.10, G11.12, and G11.19. N18.3 was deleted from ICD-10 Codes that Support Medical Necessity, Group 1 and replaced by N18.30, N18.31, and N18.32.

Billing and Coding: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (A57092)

Based on the annual ICD-10 code update, the descriptor has changed for ICD-10 codes Z68.1, Z68.20, Z68.21, Z68.22, Z68.23, Z68.24, Z68.25, Z68.26, Z68.27, Z68.28, Z68.29, Z68.30, Z68.31, Z68.32, Z68.33 and Z68.34 in Group 2.

Billing and Coding: Ibandronate Sodium (A52421)

Based on the annual ICD-10 code update, ICD-10 codes M80.0AXA, M80.0AXD, M80.0AXG, M80.0AXK, M80.0AXP and M80.0AXS have been added to code range M80.00XA - M80.88XS and ICD-10 codes M80.8AXA, M80.8AXD, M80.8AXG, M80.8AXK, M80.8AXP and M80.8AXS have been added to Group 2. ICD-10 codes K20.8 and K20.9 have been deleted and replaced by K20.80, K20.81, K20.90 and K20.91 in Coding Information Guideline 1 and Group 3 in the ICD-10 Codes that Support Medical Necessity section.

Billing and Coding: Infliximab and biosimilars (A52423)

Based on the annual ICD-10 update, ICD-10 codes M05.7A and M05.8A have been added to ICD-10 code range M05.00-M05.9, ICD-10 code M06.0A has been added to ICD-10 code range M06.00-M06.39, ICD-10 code M06.8A has been added to ICD-10 code range M06.80-M06.9, ICD-10 code M08.0A has been added to ICD-10 code range M08.00-M08.29 and ICD-10 codes M08.2A and M08.9A have been added in Group 2.

Billing and Coding: Intravenous Immune Globulin (IVIG) (A52446)

Based on the annual ICD-10 code update, ICD-10 code D59.1 has been deleted and replaced with D59.11, D59.12, D59.13 and D59.19.

Billing and Coding: Magnetic Resonance Angiography (MRA) (A56747)

Based on the annual ICD-10 update for 2021, ICD-10 code N18.3 has been deleted and replaced by N18.30, N18.31 and N18.32 in Groups 3 and 4 covered diagnoses. The descriptor for code Z88.8 has been revised in Group 4 covered diagnoses.

Billing and Coding: Nerve Conduction Studies and Electromyography (A57668)

Based on the annual ICD-10 updates for 2021, ICD-10 codes G11.1 and G71.2 were deleted and replaced by G11.10, G11.12, G11.19, G71.20, G71.21, G71.220, G71.228, and G71.29 in Group 1 covered diagnoses.

Billing and Coding: Nivolumab (A54862)

Based on FDA and Compendia review, ICD-10-CM codes C15.3, C15.4, C15.5, C15.8, C16.0, D37.8, Z85.01 have been added effective for dates of service on or after 6/10/2020.

Billing and Coding: Non-Invasive Vascular Studies (A56758)

Based on the annual ICD-10 updates for 2021, K74.0 and R74.0 were deleted from ICD-10 Codes that Support Medical Necessity, Group 5 and replaced by K74.00, K74.01, K74.02, R74.01 and R74.02.

N18.3 was deleted from ICD-10 Codes that Support Medical Necessity, Group 6 and replaced by N18.30, N18.31, and N18.32.

The following codes were added to ICD-10 Codes that Support Medical Necessity, Group 2: D57.03, D57.09, D57.413, D57.418, D57.42, D57.431, D57.432, D57.433, D57.438, D57.439, D57.44, D57.451, D57.452, D57.453, D57.458 and D57.459.

D57.411 and D57.412 descriptors were changed in ICD-10 Codes that Support Medical Necessity, Group 2.

Billing and Coding: Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) (A56726)

Due to the annual ICD-10-CM update, ICD-10-CM codes H55.81, H55.82, D57.03, D57.09, D57.213, D57.218, D57.813, and D57.818 were added to Group 3- "ICD-10-CM Codes That Support Medical Necessity" section.

ICD-10-CM code E70.8 was deleted from Group 3.

Billing and Coding: Outpatient Physical and Occupational Therapy Services (A56566)

Based on the annual ICD-10 updates for 2021, ICD-10 code J82 has been deleted and replaced by J82.81, J82.82, J82.83 and J82.89 in the list of non-covered diagnoses for CPT code 97035.

Billing and Coding: Paclitaxel (e.g., Taxol®/Abraxane ™) (A52450)

Based on compendia review, ICD-10-CM code C22.3 has been added to Group 2 for paclitaxel effective for dates of service on or after 10/01/2020.

Billing and Coding: Peripheral Nerve Blocks (A57452)

Due to the annual ICD-10 updates, ICD-10 code R51 has been deleted from Group 1 and Group 2 in the ICD-10 Codes that Support Medical Necessity section and new ICD-10 code R51.9 has been added.

In Group 2 under the “CPT/HCPCS Codes” section “Non-Covered” has been removed. The following language has also been removed from Group 2 and added to the “Article Text” section: “ "Dry needling" of ganglion cysts, ligaments, neuromas, peripheral nerves, tendon sheaths and their origins/insertions, or any tissue are non-covered procedures.” The following statement has been added to the Group 2 Paragraph under the “CPT/HCPCS Codes” section

and the Article Text: "Effective January 21, 2020, all types of acupuncture including dry needling for any condition other than chronic low back pain are non-covered by Medicare. Medicare will cover acupuncture for Medicare patients with chronic lower back pain within specific guidelines in accordance with NCD 30.3.3."

The Group 1 Paragraph under the ICD-10 Codes that Support Medical Necessity was corrected to remove the following codes: 64402 and 64413.

Billing and Coding: Psychiatric Inpatient Hospitalization (A56865)
Based on the annual ICD-10 updates for 2021, the following codes were added to ICD-10 Codes that Support Medical Necessity, Group 1: F11.13, F12.13, F13.130, F13.131, F13.132, F13.139, F14.13, F14.93, F15.13, F19.130, F19.131 and F19.132.

Billing and Coding: Psychiatric Partial Hospitalization Programs (A56850)
Based on the annual ICD-10 updates for 2021, the following codes were added to ICD-10 Codes that Support Medical Necessity, Group 1: F11.13, F12.13, F13.130, F13.131, F13.132, F13.139, F14.13, F14.93, F15.13, F19.130, F19.131 and F19.132.

Billing and Coding: Psychiatry and Psychology Services (A56937)
Based on the annual ICD-10 updates for 2021, the following codes were added to ICD-10 Codes that Support Medical Necessity, Group 1: F11.13, F12.13, F13.130, F13.131, F13.132, F13.139, F14.13, F14.93, F15.13, F19.130, F19.131 and F19.132.

Billing and Coding: RAST Type Tests (A56844)
Based on the annual ICD-10 updates for 2021, T40.4X5A, T40.4X5D and T40.4X5S were deleted from ICD-10 Codes that Support Medical Necessity and replaced by T40.495A, T40.495D and T40.495S.

Billing and Coding: Rituximab, biosimilars and Rituximab and hyaluronidase human (Rituxan Hycela™) (A52452)
Based on the annual ICD-10 code update, ICD-10 code D59.1 has been deleted and replaced with ICD-10 codes D59.11, D59.12, D59.13 and D59.19. Code range M05.00 - M05.9 has been broken out to not include new ICD-10 codes M05.7A and M05.8A, code range M06.00 - M06.39 has been broken out to not include new ICD-10 code M06.0A and code range M06.80 - M06.9 has been broken out to not include new ICD-10 code M06.8A.

Billing and Coding: Routine Foot Care and Debridement of Nails (A57759)

Based on annual ICD-10 updates for 2021, ICD-10 codes G11.1 and N18.3 were deleted and replaced by G11.10, G11.11, G11.19 for Groups 1 and 4, and N18.30, N18.31 and N18.32 for Group 1 covered diagnoses.

Billing and Coding: Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) (A56537)

Due to the annual ICD-10-CM update, the following ICD-10-CM codes M06.0A and M06.8A were added to code range M06.00 - M06.9- Group 3 (CPT code 92134) and M06.0A was added to Group1(CPT code 92132).

ICD-10-CM code H18.50 was deleted from “ICD-10-CM Codes That Support Medical Necessity” section and replaced by H18.501; H18.502, H18.503, and H18.51 was deleted and replaced by ICD-10-CM codes H18.511, H18.512, H18.513 – Group 1 (CPT code 92132)

ICD-10-CM code T86.840 was deleted from “ICD-10-CM Codes That Support Medical Necessity” section and replaced by ICD-10-CM codes T86.8401, T86.8402, T86.8403 – Group 1 (CPT code 92132)

ICD-10-CM code T86.841 was deleted from “ICD-10-CM Codes That Support Medical Necessity” section and replaced by ICD-10-CM codes T86.8411, T86.8412, T86.8413– Group 1 (CPT code 92132)

ICD-10-CM code T86.842 was deleted from “ICD-10-CM Codes That Support Medical Necessity” section and replaced by ICD-10-CM codes T86.8421, T86.8422, T86.8423– Group 1 (CPT code 92132)

ICD-10-CM code Z03.823 was added to Group 4.

ICD-10-CM codes, H18.521, H18.522, H18.523, H18.531, H18.532, H18.533, H18.541, H18,542, H18.543, H18.551, H18.552, H18.553, H18.591, H18.592, H18.593, T86.8481, T86.8482, T86.8483, T86.8491, T86.8492, T86.8493 were added to the “ICD-10-CM Codes That Support Medical Necessity” section – Group 1 (CPT code 92132).

Billing and Coding: Select Minimally Invasive GERD Procedures (A56863)
Based on the annual ICD-10 code update, ICD-10-CM code K21.0 has been deleted and replaced with K21.00.

Billing and Coding: Stem Cell Transplantation (A52879)
Based on the annual ICD-10 code update, the descriptor for ICD-10 codes D57.411, D57.412 and D57.419 has been changed in Group 1.

Billing and Coding: Urine Drug Testing (A56761)
Based on the annual ICD-10 updates for 2021, T40.4X1A, T40.4X2A, T40.4X3A and T40.4X4A were deleted from ICD-10 Codes that Support Medical Necessity and replaced by T40.491A, T40.492A, T40.493A and T40.494A.

Billing and Coding: Visual Fields Testing (A56551)

Due to the annual ICD-10-CM update, diagnosis codes G40.42, M05.8A, and H55.82 were added to the "ICD-10-CM Codes That Support Medical Necessity" section- Group1- (CPT codes 92081, 92082, and 92083)

ICD-10-CM code H55.81 descriptor was changed in Group 1

Billing and Coding: Vitamin D Assay Testing (A57736)
Based on the annual ICD-10 code update the following changes have been made in Group 1: ICD-10-CM codes M80.0AXA, M80.0AXD, M80.0ASG, M80.0AXK, M80.0AXK and M80.0AXS have been added to code range M80.00XA - M80.88XS and ICD-10-CM codes M80.8AXA, M80.8AXD, M80.8AXG, M80.8AXK, M80.8AXP and M80.8AXS have been added. ICD-10-CM code N18.3 has been deleted and replaced with N18.30, N18.31 and N18.32. The description for ICD-10-CM codes Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44 and Z68.45 has been changed.

Health and Behavior Assessment/Intervention – Medical Policy Article (A52434)
Based on the annual ICD-10 updates for 2021, the following codes were added to ICD-10 Codes that DO NOT Support Medical Necessity, Group 1: F10.130, F10.131, F10.132, F10.139, F10.930, F10.931, F10.932, F10.939, F11.13, F12.13, F13.130, F13.131, F13.132, F13.139, F14.13, F14.93, F15.13, F19.130, F19.131, F19.132 and F19.139.

Laparoscopic Sleeve Gastrectomy (LSG) – Medical Policy Article (A52447)
Based on the annual ICD-10 updates for 2021, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44 and Z68.45 descriptors were changed in ICD-10 Codes that Support Medical Necessity, Group 2.

Chronic Care Management

Insufficient documentation causes most improper payments. Insufficient documentation means that something was missing from the medical records. Below is a list of the most common reasons CERT determined there was insufficient documentation that caused improper payments for CCM services:

- Missing documentation that support CCM was performed;
- Missing CCM care plan with documentation that it was provided to the beneficiary or beneficiary's caregiver;
- Missing patient agreement or consent for CCM;
- Missing electronic signature or legible signature of the performing provider

Related Content

- Care Management: fact sheets, frequently asked questions, and information on chronic conditions in Medicare
- MLN Bookle®: *Chronic Care Management Services*
- Connected Care Toolkit: Chronic Care Management Resources for Health Care Professionals and Communities
- YouTube Video: Connected Care: Physician Testimonial about Chronic Care Management
- Centers for Medicare & Medicaid Services Internet-Only Manual, Publication 100-8, *Medicare Program Integrity Manual*, Chapter 3, (Signature Requirements)