Medicare Bulletin

JURISDICTION 15

HOME HEALTH & HOSPICE

Reaching Out
to the Medicare
Community

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HOME HEALTH PROVIDERS

MM11081 (Revised): Home Health Patient-Driven Groupings Model (PDGM) - Split Implementation .............. 3

MM11536 (Revised): Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020 .................................................. 5

FOR HOSPICE PROVIDERS

Hospice Self-Determined Aggregate Cap Reminder ....... 10

2020 Home Health & Hospice Provider Outreach and Education (POE) Advisory Group Membership Drive .... 10

Contact Information for CGS Medicare Home Health and Hospice Providers .................................... 11

MLN Connects® Weekly News ...................................... 12

MM11335 (Revised): Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS .......................................................... 13

MM11554: Manual Update to Publication (Pub.) 100-04, Chapter 20, to Revise the Section 10 - Where to Bill Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) Items and Services .............. 14

MM11560: Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List .................................................. 16

MM11570: CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule .................................................... 20

Provider Contact Center (PCC) Training ......................... 27

SE19029 (Revised): Medicare Part B Home Infusion Therapy Services With The Use of Durable Medical Equipment .................................................. 28

Upcoming Educational Events ....................................... 33

Update to the Interest Paid on Clean Non-PIP Claims Not Paid Timely .................................................... 33

New Medicare Beneficiary Identifier (MBI)

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FOR HOME HEALTH PROVIDERS

MM11081 (Revised): Home Health Patient-Driven Groupings Model (PDGM) - Split Implementation

The Centers for Medicare & Medicaid Services (CMS) revised the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index

MLN Matters Number: MM11081 Revised Related CR Release Date: December 20, 2019
Related CR Transmittal Number: R4482CP Effective Date: January 1, 2020 Claim “From” dates
Implementation Date: January 6, 2020 on or after this date.

Note: We revised the article on December 23, 2019, to reflect a revised CR11081 that CMS issued on December 20. The revisions to the CR did not affect the content of the article. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for home health (HH) services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11081 effectuates the policies of the Patient-Driven Groupings Model (PDGM) as described in the November 2018 HH final rule. Please make sure your billing staff is aware of these changes.

BACKGROUND

Since October 2000, HH agencies (HHAs) are paid under a prospective payment system (HH PPS) for a 60-day episode of care that includes all covered HH services. The 60-day payment amount is adjusted for case-mix and area wage differences. Additionally, HH episodes of care can receive higher payments if certain therapy thresholds are met. As part of the HH PPS payment structure, HHAs receive approximately half of the expected final payment amount up front, after performing the first visit in a 60-day episode of care, with the remaining amount received at the end of the 60-day episode of care upon final claim submission.

In early February of 2018, Section 51001 of the Bipartisan Budget Act of 2018 (BBA of 2018) became law and included several requirements for HH payment reform, effective January 1, 2020. These reforms included the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of service to a 30-day unit of service. In the CY 2019 final HH PPS Rate Update final rule, CMS finalized an alternative case-mix method called...
CR 11081 Key points

CR 11081 effectuates the policies of the PDGM, as described in the CY 2019 HH final rule available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notifications-Items/CMS-1689-FC.html and as required by Section 51001 of the BBA of 2018.

These policies include a change to the unit of payment from 60-day episodes of care to 30-day periods of care and the elimination of therapy thresholds for use in determining HH payment. The PDGM will assign 30-day periods of care into one of 432 case-mix groups based on the following variables:

- Timing: The first 30-day period of care is an early period of care. The second or later 30-day period of care is a late period of care;
- Admission Source: If the patient was referred to HH from the community or an acute or post-acute care referral source;
- Clinical Group: The primary reason the patient requires home care, represented by distinct clinical groups as determined by the principal diagnosis reported on the HH claim;
- Functional Impairment Level: The patient’s functional impairment level is based on OASIS items for activities of daily living; and
- Comorbidity Adjustment: If the patient has certain comorbid conditions reported on the HH claim, the 30-day period of care can receive a no, low, or high comorbidity adjustment.

In conjunction with the PDGM, this final rule implements a change to the Low-Utilization Payment Adjustment (LUPA) threshold from the current four or fewer visits per 60-day episode of care to thresholds that vary based on the 10th percentile of visits in a 30-day period of care for each case-mix group in the PDGM.

Beginning in CY 2020, HHAs that are certified for participation in Medicare on or after January 1, 2019, will no longer receive split-percentage payments. HHAs that are certified for participation in Medicare effective on or after January 1, 2019, would still be required to submit a “no pay” Request for Anticipated Payment (RAP) at the beginning of care to establish the HH period of care, as well as, every 30 days thereafter upon implementation of the PDGM in CY 2020.

Existing HHAs, meaning those HHAs certified for participation in Medicare prior to January 1, 2019, will continue to receive RAP payments upon implementation of the PDGM in CY 2020. For split percentage payments to be made, existing HHAs would have to submit a RAP at the beginning of each 30-day period of care. For the first 30-day period of care, the split percentage payment would be 60/40 and all subsequent 30-day periods of care would be a split percentage payment of 50/50. Please note that a final claim must be submitted at the end of each 30-day period of care.

Note from CGS: As described in the Calendar Year (CY) 2020 home health (HH) final rule at https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24026.pdf, the split percentage payment in calendar year 2020 will be 20/80 for the initial and subsequent periods of care.

ADDITIONAL INFORMATION

The official instruction, CR11081, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/R4482CP.pdf. If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.
FOR HOME HEALTH PROVIDERS

MM11536 (Revised): Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020

The Centers for Medicare & Medicaid Services (CMS) revised the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index

MLN Matters Number: MM11536 Revised
Related CR Release Date: November 22, 2019
Related CR Transmittal Number: R4466CP
Related Change Request (CR) Number: 11536
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

NOTE: We revised this article on December 3, 2019, due to a revised Change Request (CR) which corrected the LUPA add-on factors in the 2020 record layout in manual Section 70.2. The transmittal number, CR release date and link to the transmittal also changed in the article. All other information remains the same.

PROVIDER TYPES AFFECTED
This MLN Matters Article is intended for Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW
CR 11536 updates the CY 2020 60-day and 30-day base payment rates, the national per-visit amounts, Low-Utilization Payment Adjustment (LUPA) add-on amounts, the non-routine medical supply payment amounts, and the cost-per-unit payment amounts used for calculating outlier payments under the HH PPS. In addition, this CR revises the initial payment percentage for both initial and subsequent 30-day periods of care under the split percentage payment approach for CY 2020. Make sure that your billing staffs are aware of these changes.

BACKGROUND
The Medicare HH Prospective Payment System (HH PPS) rates provided to HH agencies (HHAs) for furnishing HH services are updated annually as required by Section 1895(b)(3)(B) of the Social Security Act (the Act). The CY 2020 HH PPS rate update includes implementation of the Patient-Driven Groupings Model (PDGM), a revised case-mix adjustment methodology for HH services beginning on or after January 1, 2020.

The CY 2020 HH PPS rate update implements a change in the unit of payment from a 60-day episode of care to a 30-day period of care as required by Section 1895(b)(2)(B) of the Act, as...
amended by Section 51001(a)(1) of the Bipartisan Budget Act (BBA) of 2018. This rate update will increase the CY 2020 60-day and 30-day base payment rates by the appropriate rural add-on percentage prior to applying any case-mix and wage index adjustments, as required by Section 421(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), as amended by Section 50208(a) of the BBA of 2018.

Finally, in CY 2020, for existing HHAs (that is, HHAs certified for participation in Medicare with effective dates prior to January 1, 2019), the split-percentage payment will be reduced from the current 60/50 percent (dependent on whether the request for anticipated payment (RAP) is for an initial or subsequent period of care) to 20 percent in CY 2020 for all 30-day HH periods of care (both initial and subsequent periods of care).

Newly-enrolled HHAs (that is, HHAs certified for participation in Medicare effective on or after January 1, 2019), will not receive split-percentage payments for CY 2020 but are required to submit “no-pay” RAPs for all 30-day HH periods of care.

Market Basket Update

Section 53110 of the BBA of 2018 amended Section 1895(b)(3)(B) of the Act, such that for HH payments for CY 2020, the HH payment update is required to be 1.5 percent. The multifactor productivity (MFP) adjustment is not applied to the BBA of 2018 mandated 1.5 percent payment update. Section 1895(b)(3)(B) of the Act requires that the HH payment update be decreased by 2 percentage points for those HHAs that do not submit quality data as required by the Secretary. For HHAs that do not submit the required quality data for CY 2020, the HH payment update would be -0.5 percent (1.5 percent minus 2 percentage points).

National, Standardized 60-Day Episode Payment and 30-Day Period Payment Amounts

As finalized in the CY 2019 HH PPS final rule, the unit of HH payment will change from a 60-day episode to a 30-day period effective for those 30-day periods beginning on or after January 1, 2020. The standardized 60-day payment rate will apply to case-mix adjusted episodes (that is, not low-utilization payment adjustments (LUPAs)) beginning on or before December 31, 2019, and ending on or after January 1, 2020. As such, the latest date a 60-day crossover episode could end on is February 28, 2020. Those 60-day episodes that begin on or before December 31, 2019, but are LUPA episodes, will be paid the national, per-visit payment rates.

To determine the CY 2020 national, standardized 60-day episode payment rate for those 60-day episodes that span the implementation date of the PDGM and the change to a 30-day unit of payment, CMS applies a wage index budget neutrality factor of 1.0060 and the HH payment update percentage of 1.5 percent for HHAs that submit the required quality data and by 1.5 percent minus 2 percentage points, or 0.5 percent for HHAs that do not submit the required quality data. These two episode payment rates are shown in Tables 1 and 2.

<table>
<thead>
<tr>
<th>Table 1 - CY 2020 National, Standardized 60-Day Episode Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2019 National, Standardized 60-Day Episode Payment</td>
</tr>
<tr>
<td>$3,154.27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2 - CY 2020 National, Standardized 60-Day Episode Payment Amount for HHAs That Do Not Submit the Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2019 National, Standardized 60-Day Episode Payment</td>
</tr>
<tr>
<td>$3,154.27</td>
</tr>
</tbody>
</table>

To determine the CY 2020 national, standardized 30-day period payment rate beginning January 1, 2020, CMS applies a wage index budget neutrality factor of 1.0063 and the HH payment update percentage of 1.5 percent for HHAs that submit the required quality data and by
1.5 percent minus 2 percentage points, or -0.5 percent for HHAs that do not submit the required quality data. These two episode payment rates are shown in Tables 3 and 4.

### Table 3 - CY 2020 National, Standardized 30-Day Period Payment Amount

<table>
<thead>
<tr>
<th>CY 2019 30-day Budget Neutral (BN) Standard Amount</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2020 HH Payment Update</th>
<th>CY 2020 National, Standardized 30-Day Period Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,824.99</td>
<td>X 1.0063</td>
<td>X 1.015</td>
<td>$1,864.03</td>
</tr>
</tbody>
</table>

### Table 4 - CY 2020 National, Standardized 30-Day Period Payment Amount for HHAS That Do Not Submit the Quality Data

<table>
<thead>
<tr>
<th>CY 2019 National, Standardized 30-Day Period Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2020 HH Payment Update Minus 2 Percentage Points</th>
<th>CY 2020 National, Standardized 30-Day Period Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,824.99</td>
<td>X 1.0063</td>
<td>X 0.995</td>
<td>$1,827.30</td>
</tr>
</tbody>
</table>

The payments for both the CY 2020 national, standardized 60-day episode payment rate and the CY 2020 national, standardized 30-day period payment rate are further adjusted by the individual episode’s case-mix weight and by the applicable wage index.

### National Per-Visit Rates

In order to calculate the CY 2020 national per-visit payment rates, CMS starts with the CY 2019 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0066 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2020 wage index. The per-visit rates are then updated by the CY 2020 HH payment update of 1.5 percent for HHAs that submit the required quality data and by 0.995 for HHAs that do not submit quality data. The per-visit rates are shown in Tables 5 and 6.

### Table 5 - CY 2020 National Per-Visit Payment Amounts for HHAS

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>CY 2019 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2020 HH Payment Update</th>
<th>CY 2020 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$66.34</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$67.78</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$234.82</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$239.92</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$161.24</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$164.74</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$160.14</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$163.61</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$146.50</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$149.68</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$174.06</td>
<td>X 1.0066</td>
<td>X 1.015</td>
<td>$177.84</td>
</tr>
</tbody>
</table>

### Table 6 - CY 2020 National Per-Visit Payment Amounts for HHAS That Do Not Submit the Required Quality Data

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>CY 2019 Per-Visit Rates</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2020 HH Payment Update Minus 2 Percentage Points</th>
<th>CY 2020 Per-Visit Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$66.34</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$66.44</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$234.82</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$235.19</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$161.24</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$161.49</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$160.14</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$160.39</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$146.50</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$146.73</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$174.06</td>
<td>X 1.0066</td>
<td>X 0.995</td>
<td>$174.33</td>
</tr>
</tbody>
</table>

### Non-Routine Supply Payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. In CY 2020, the NRS payment amounts apply to only those 60-day episodes that begin on or before December 31, 2019, but span the implementation of the PDGM and the 30-day unit of payment on January 1, 2020 (ending in CY 2020, on or before February 28, 2020). Under the PDGM, NRS payments are included in the 30-day base payment rate. To determine the CY 2020 NRS conversion factors, CMS updates the CY 2019 NRS conversion factor by the CY 2020 HH payment update of 1.5 percent for HHAs that submit the required quality data and by 0.995 for HHAs that do not submit quality data.

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quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2020 payments for HHAs that do submit the required quality data is shown in Table 7. The payment amounts for the various NRS severity levels are shown in Table 8. The NRS conversion factor for CY 2020 payments for HHAs that do not submit quality data is shown in Table 9 and the payment amounts for the various NRS severity levels are shown in Table 10.

Table 7- CY 2020 NRS Conversion Factor

<table>
<thead>
<tr>
<th>CY 2019 NRS Conversion Factor</th>
<th>CY 2020 HH Payment Update</th>
<th>CY 2020 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$54.20</td>
<td>X 1.015</td>
<td>$55.01</td>
</tr>
</tbody>
</table>

Table 8 - CY 2020 NRS Payment Amounts

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2020 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.84</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$53.59</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$146.94</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$218.31</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$336.65</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$579.00</td>
</tr>
</tbody>
</table>

Table 9 - CY 2020 NRS Conversion Factor for HHAs That Do Not Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2019 NRS Conversion Factor</th>
<th>CY 2020 HH Payment Update Percentage Minus 2 Percentage Points</th>
<th>CY 2020 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$54.20</td>
<td>X 0.995</td>
<td>$53.93</td>
</tr>
</tbody>
</table>

Table 10 - CY 2020 NRS Payment Amounts for HHAs That Do Not Submit the Required Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2020 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.55</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$52.54</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$144.06</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$214.03</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$330.04</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$567.63</td>
</tr>
</tbody>
</table>

Rural Add-On Provision

In the CY 2019 HH PPS final rule (83 FR 56443), CMS finalized policies for the rural add-on payments for CY 2019 through CY 2022, in accordance with section 50208 of the BBA of 2018. The CY 2019 HH PPS proposed rule (83 FR 32373) described the provisions of the rural add-on payments, the methodology for applying the new payments, and outlined how CMS categorized rural counties (or equivalent areas) based on claims data, the Medicare Beneficiary Summary File and Census data.

CY 2020 HH PPS payments will be increased by 0.5 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the “High utilization” category. CY 2020 HH PPS payments will be increased by 3.0 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the “Low population density” category. CY 2020 HH PPS payments will be increased by 2.0 percent when services are provided to beneficiaries who reside in rural counties and equivalent areas in the “All other” category.

The HH PRICER module, located within the CMS claims processing system, will increase the final CY 2020 60-day and 30-day base payment rates by the appropriate rural add-on percentage prior to applying any case-mix and wage index adjustments.
Outlier Payments

The fixed dollar loss (FDL) ratio and the loss-sharing ratio used to calculate outlier payments must be selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by section 1895(b)(5)(A) of the Act). Historically, CMS has used a value of 0.80 for the loss-sharing ratio which CMS believes, preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount. No changes were made to the loss-sharing ratio of 0.80 for CY 2020.

For CY 2020, the FDL ratio for 60-day episodes that span the implementation date of the PDGM will remain 0.51. The FDL ratio for 30-day periods of care in CY 2020 is 0.56. In the CY 2017 HH PPS final rule (81 FR 76702), CMS finalized changes to the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. This change in methodology allows for more accurate payment for outlier episodes, accounting for both the number of visits during an episode of care and also the length of the visits provided. Using this approach, CMS now converts the national per-visit rates into per 15-minute unit rates. These per 15-minute unit rates are used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. The cost-per-unit payment rates used for the calculation of outlier payments are in Table 11.

<table>
<thead>
<tr>
<th>HH Discipline</th>
<th>Average Minutes Per-Visit</th>
<th>For HHAs that DO Submit the Required Quality Data</th>
<th>For HHAs that DO NOT Submit the Required Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CY 2020 Per-Visit Payment</td>
<td>Cost-per-unit (1 unit= 15 minutes)</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>63.0</td>
<td>$67.78</td>
<td>$16.14</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>56.5</td>
<td>$239.92</td>
<td>$63.70</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>47.1</td>
<td>$164.74</td>
<td>$52.46</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>46.6</td>
<td>$163.61</td>
<td>$52.66</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>44.8</td>
<td>$149.68</td>
<td>$50.12</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>48.1</td>
<td>$177.84</td>
<td>$55.46</td>
</tr>
</tbody>
</table>

Split Percentage Payment

Medicare makes a split percentage payment for most HH PPS episodes/periods. The first payment is in response to a Request for Anticipated Payment (RAP), and the last in response to a claim. Added together, the first and last payment equals 100 percent of the permissible payment for the episode. The current split percentage payments are 60/40 (for initial episodes of care) and 50/50 (for subsequent episodes of care).

For CY 2020, the split-percentage payment for existing HHAs will be reduced to 20 percent in CY 2020 for all 30-day HH periods of care (both initial and subsequent periods of care).

In the CY 2019 HH PPS final rule (83 FR 56628), CMS finalized that newly-enrolled HHAs, that is HHAs certified for participation in Medicare effective on or after January 1, 2019, will not receive split-percentage payments beginning in CY 2020. HHAs that are certified for participation in Medicare effective on or after January 1, 2019, will still be required to submit a “no pay” Request for Anticipated Payment (RAP) at the beginning of a period of care in order to establish the HH period of care, as well as every 30 days thereafter.

ADDITIONAL INFORMATION

The official instruction, CR11536, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r4466cp.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.
FOR HOSPICE PROVIDERS

Hospice Self-Determined Aggregate Cap Reminder

The Centers for Medicare & Medicaid Services (CMS) published the fiscal year (FY) 2015 Hospice Wage Index and Payment Rate Update final rule on August 22, 2014. The final rule included a requirement for hospices to file a self–determined hospice aggregate cap. **Hospices are required to file the self-determined cap each year, between December 31 and February 28 (2/29 in leap years). Due to 2/29/20 falling on a Saturday the 2019 Self-Determined Caps are due no later than March 2, 2020.**

As a reminder, the Hospice Caps Web page at [https://www.cgsmedicare.com/hhh/audit/hos_caps.html](https://www.cgsmedicare.com/hhh/audit/hos_caps.html) was created on the CGS website to assist hospices with this process. This Web page includes a link to the “Provider Self-Determined Aggregate Cap Limitation” form, as well as instructions for completing the form.

Hospices are responsible for obtaining their own Provider Statistical and Reimbursement (PS&R) summary from the CMS website at [https://psr-ui.cms.cmsnet/psr-ui](https://psr-ui.cms.cmsnet/psr-ui). CGS will not provide this to hospices. An instruction for obtaining your PS&R reports is also available from the Hospice Caps Web page at [https://www.cgsmedicare.com/hhh/audit/hos_caps.html](https://www.cgsmedicare.com/hhh/audit/hos_caps.html). If a hospice is unable to obtain a copy of their PS&R reports, please contact Tom Bisbee at CGS, at 1.615.660.5560 for assistance.

Refer to the Hospice Caps Web page at [https://www.cgsmedicare.com/hhh/audit/hos_caps.html](https://www.cgsmedicare.com/hhh/audit/hos_caps.html) for more detailed information about this process and links to additional resources.

FOR HOME HEALTH AND HOSPICE PROVIDERS

2020 Home Health & Hospice Provider Outreach and Education (POE) Advisory Group Membership Drive

CGS invites interested parties to participate in our Home Health and/or Hospice Provider Outreach and Education Advisory Groups (POE AGs). The primary function of each Advisory Group is to assist CGS in the creation, implementation, and review of provider education strategies and efforts. The Advisory Group members provide input and feedback on training topics, provider education materials, and dates and locations of provider education workshops and events. The group also identifies salient provider education issues, and recommends effective means of information dissemination to all appropriate providers and their staff, including the use of the Provider Contact Center (PCC) to disseminate information to providers. Reference: CMS Medicare Contractor Beneficiary and Provider Communications Manual (Pub. 100-09), chapter 6, section 20.6.1 at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/com109c06.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/com109c06.pdf).

Currently, our Advisory Groups encompass a number of state and national organization officials. We are looking to expand and diversify our groups to include more individual providers and
representatives of home health and hospice agencies. Membership will consist of a two year commitment. CGS has created the Provider Outreach & Education Advisory Group Covenant (https://www.cgsmedicare.com/hhh/education/pdf/hhh_poe_ag_covenant.pdf) that summarizes the purpose and goals of the group. The covenant also details the responsibilities of CGS as the Medicare Administrative Contractor (MAC) and you as an active member.

Registration for the 2020 J15 Home Health and Hospice POE-AGs began January 14, 2020, and is scheduled to close February 14, 2020. Please consider this opportunity to share your feedback about educational efforts made available by CGS. If you are interested in joining either group or have any questions, send them to our education mailbox at J15_HHH_Education@cgsadmin.com.

FOR HOME HEALTH AND HOSPICE PROVIDERS

CGS Website Updates

CGS has recently made updates to their website, giving providers additional resources to assist with billing Medicare-covered services appropriately.

Please review the following updates:

- The Claims Processing Issues Log Web page at https://www.cgsmedicare.com/hhh/claims/fiss_claims_processing_issues.html was updated with the most recent updates.
- The Top Claim Submission Errors (Reason Codes) and How to Resolve Web page at https://www.cgsmedicare.com/hhh/education/materials/cses.html has been updated with the most recent data.
- The Self-Service Options Web page at https://www.cgsmedicare.com/hhh/tools/index.html has been updated to include the following NEW Home Health Patient-Driven Groupings Model (PDGM) resources.
  - Home Health Patient-Driven Groupings Model (PDGM) 30-Day Period of Care Billing Schedule at https://www.cgsmedicare.com/hhh/education/materials/pdf/pdgm_30_day.pdf will assist in determining the 30-day period for the From/Through dates of service.
  - Home Health Patient-Driven Groupings Model (PDGM) Admission Source 14-day Calculator at https://www.cgsmedicare.com/medicare_dynamic/j15/pdgm_14_day_calc/pdgm_14_day_calc.aspx will calculate the 14 day period prior to the home health admission to assist with determining whether the admission source is institutional or community and if occurrence code 61 or 62 should be reported.
  
  These self-service options are also available on the Home Health Patient-Driven Groupings Model (PDGM) Web page at https://www.cgsmedicare.com/hhh/education/materials/pdgm.html.

- The Home Health Medicare Billing Codes Sheet at https://www.cgsmedicare.com/hhh/education/materials/pdf/home_health_billing_codes.pdf has been updated to include PDGM claim information.
- The HHH Recorded Webinars Web page at https://www.cgsmedicare.com/hhh/education/recorded_webinars.html has been updated to include December 2019 webinar recordings.
- The Home Health Payment Rates Web page at https://www.cgsmedicare.com/hhh/claims/fees/hhpps_rates.html has been updated to include the Calendar Year 2020 rates.
- The Jurisdiction 15 Home Health & Hospice Provider Outreach and Education (POE) Advisory Group Web page at https://www.cgsmedicare.com/hhh/education/advisory...
groups.html has been updated to include the December 2019 home health and hospice meeting minutes, and the upcoming 2020 meeting dates.


- The questions and answers provided on the J15 HH&H FAQ Topics Web page at https://www.cgsmedicare.com/medicare_dynamic/faqs/J15hhh.asp were reviewed and updated as needed.

FOR HOME HEALTH AND HOSPICE PROVIDERS

Contact Information for CGS Medicare Home Health and Hospice Providers

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center (PCC) at 1.877.299.4500 and choose Option 1. Access the Home Health and Hospice “Contact Information” web page at https://www.cgsmedicare.com/hhh/cs/index.html for information about the Interactive Voice Response (IVR) system, as well as telephone numbers, fax numbers, and mailing addresses for other CGS departments.

BEFORE YOU CALL

Access the “How Do I…?” icon (https://www.cgsmedicare.com/hhh/cs/howdoi.html) from the Home Health & Hospice Contact Information page at https://www.cgsmedicare.com/hhh/cs/index.html. In addition, refer to the “Education & Resources Options” icon (https://www.cgsmedicare.com/hhh/education/index.html) to access resources that may be able to answer your question.

MLN Connects® Weekly News

The MLN Connects® is the official news from the Medicare Learning Network and contains a weeks’ worth of Medicare-related messages. These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. The following provides access to the weekly messages. Please share with appropriate staff. If you wish to receive the listserv directly from CMS, refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNgenInf/index.html.

MM11335 (Revised): Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS

The Centers for Medicare & Medicaid Services (CMS) revised the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index

MLN Matters Number: MM11335 Revised
Related CR Release Date: December 13, 2019
Related CR Transmittal Number: R2408OTN
Related Change Request (CR) Number: 11335
Effective Date: April 1, 2020
Implementation Date: April 6, 2020

Note: We revised this article on December 13, 2019, due to an updated Change Request (CR) that added the business requirement 11335.9 in the CR for contractor integration testing. We also changed the CR release date, transmittal number and link to the transmittal. All other information remains the same.

PROVIDER TYPES AFFECTED
This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for Pneumococcal Pneumonia Vaccination (PPV) services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW
CR 11335 instructs Medicare’s Common Working File (CWF) to send the Date of Service (DOS) for both PPV HCPCS codes (90670 and 90732) to the Medicare Beneficiary Database (MBD). This will allow other systems to know whether the DOS was for the initial vaccine or the second vaccine. Once the CR is implemented, providers will receive more detail in reply to eligibility transactions on whether their beneficiaries have received one or both PPV vaccines.

BACKGROUND
Currently, the CWF groups these two HCPCS codes under the PPV HCPCS group code and sends a single next eligible date from the CWF to the MBD. There is no logic included on the MBD to differentiate between the initial vaccine (code 90670) and the second vaccine (code 90732).

For eligibility transactions, CWF processes the two codes as if they were the same code and stores the next eligible date in the one field that exists in the CWF Beneficiary Master File for PPV. This means that the date stored in this field may represent the date of the Initial dose or the second dose.

Eligibility transactions have a need to return the PPV DOS as well as the related National Provider Identifier (NPI) for both of these PPV HCPCS codes (90670 and 90732) for a beneficiary, so that a provider may determine if a beneficiary is eligible for either service, or if the beneficiary has already received both vaccines.

With CR 11335, eligibility transactions will be able to send providers more PPV details for a beneficiary. This includes up to 10 occurrences of historical PPV HCPCS codes, NPI, and DOS for each beneficiary.

ADDITIONAL INFORMATION
The official instruction, CR11335, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r2408otn.
If you have questions, your MACs may have more information. Find their website at [http://go.cms.gov/MAC-website-list](http://go.cms.gov/MAC-website-list).

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

**DOCUMENT HISTORY**

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**FOR HOME HEALTH AND HOSPICE PROVIDERS**

**MM11554**: Manual Update to Publication (Pub.) 100-04, Chapter 20, to Revise the Section 10 - Where to Bill Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) Items and Services

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index)

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<td>Implementation Date: March 23, 2019</td>
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**PROVIDER TYPES AFFECTED**

This MLN Matters® Article is for providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Durable Medical Equipment, Prosthetics, and Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) items or services paid under the DMEPOS fee schedule.

**WHAT YOU NEED TO KNOW**

CR 11554 updates the Medicare Claims Processing Manual with previously published instructions from CR 5917 Claims Jurisdiction and Enrollment Procedures for Suppliers of Certain Prosthetics, Durable Medical Equipment (DME) and Replacement Parts, Accessories and Supplies (Transmittal 1603, September 26, 2008) and CR 6573 Additional Instructions on Processing Claims for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items Submitted Under the Guidelines Established in Change Request 5917(Transmittal 531, August 14, 2009). CR 11554 does not convey any Medicare policy changes.

**BACKGROUND**

Suppliers enrolled with the National Supplier Clearinghouse (NSC) as a DMEPOS supplier should enroll with and bill to the A/B MAC Part B for replacement parts, accessories, and supplies for prosthetic implants and surgically implanted DME items. Suppliers should bill to A/B MAC Part B as long as those items are not billable to the A/B MAC Part A as identified in the
bulleted list below. Such suppliers should bill the A/B MAC Part B for these items only, unless the entity separately qualified as a supplier for items and/or services in another benefit category.

- Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Outpatient Physical Therapy (OPT), and hospitals bill the A/B MAC Part A for prosthetic/orthotic devices, supplies, and covered outpatient DME and oxygen (refer to Chapter 20, Section 40 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf).

- Home Health Agencies (HHAs) should bill DME to the A/B MAC (Home Health & Hospice (HHH)) or should meet the requirements of a DME supplier and bill the DME MAC. This is the HHA’s decision. A/B MACs Part A other than A/B MACs (HHH) will receive claims only for the class, “Prosthetic and Orthotic Devices.”

- Unless billing to the A/B MAC Part A is required as outlined in the preceding bullet, submit claims for implanted DME, implanted prosthetic devices, replacement parts, accessories, and supplies for the implanted DME to the A/B MACs Part B and not the DME MAC.

- Suppliers that enroll with the NSC as a DMEPOS supplier should bill the A/B MAC Part B using their National Provider Identifier (NPI) and should not include their NSC number on the claim.

- Under no circumstances should any entity enrolled as a DMEPOS supplier with the NSC bill the A/B MAC Part B for an implanted device unless you are the physician or provider that implants the device. However, DMEPOS suppliers should bill for any of the replacement parts, accessories, or supplies for prosthetic implants and surgically implanted DME.

- The supplier’s location determines the claims filing jurisdiction for these items in accordance with Chapter 1, Section 10 of the Medicare Claims Processing Manual. With respect to payment for these items, contractors take note of the longstanding policy for payment of DMEPOS items, which specifies that payment for DMEPOS is based on the fee schedule amount for the State where the beneficiary maintains his/her permanent residence. (See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf.)

In late spring, there is an annual update of the HCPCS codes that describe these categories of service. Bill all other DMEPOS items to the DME MAC. See Chapter 23, Section 20.3 of the Medicare Claims Processing Manual for additional information at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf.

A spreadsheet containing an annual updated list of HCPCS for DME MAC and B MAC jurisdictions is posted at https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html.

ADDITIONAL INFORMATION

The official instruction, CR 11554, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/R4478cp.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.


MM11560: Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

The Centers for Medicare & Medicaid Services (CMS) revised the following Medicare Learning Network (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index

MLN Matters Number: MM11560
Related Change Request (CR) Number: 11560
Related CR Release Date: November 27, 2019
Effective Date: January 1, 2020
Related CR Transmittal Number: R4468CP
Implementation Date: January 6, 2020

PROVIDER TYPES AFFECTED
This MLN Matters Article is for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services paid under the Medicare Physician Fee Schedule (MPFS) and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
CR 11560 provides a summary of the policies in the CY 2020 MPFS Final Rule, announces the Telehealth Originating Site Facility Fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2020. Make sure your billing staffs are aware of these updates.

BACKGROUND
Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish, by regulation, a fee schedule of payment amounts for physicians’ services for the subsequent year.

The Centers for Medicare & Medicaid Services (CMS) final rule that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2020, went on display on November 1, 2019. The final rule also addresses public comments on Medicare payment policies CMS proposed earlier this year. You can find the final rule at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.html.

Medicare Telehealth Services
For CY 2020, CMS is finalizing the proposals to add HCPCS codes G2086, G2087, and G2088 (which describe a bundled episode of care for treatment of opioid use disorders) to the list of telehealth services:
Telehealth Origination Site Facility Fee Payment Amount Update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth origination site fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth origination site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act.

The MEI increase for 2020 is 1.9%. Therefore, for CY 2020, the payment amount for HCPCS code Q3014 (Telehealth origination site facility fee) is 80 percent of the lesser of the actual charge, or $26.65. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Medical Record Documentation

CMS is finalizing, for CY 2020, a proposal to reduce burden by implementing a broadened general principle beyond teaching physicians that will allow:

1. All physicians,
2. Physician Assistants (PAs),
3. Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs), and Certified Registered Nurse Anesthetists (CRNAs), each of whom are recognized as Advanced Practice Registered Nurses (APRNs),

...to review and verify (sign/date) documentation in medical records without having to re-document notes the record already includes.

This principle applies to all Medicare-covered professional services that each of these professional disciplines furnish, and that are paid under the MPFS.

In addition to physicians, residents, nurses, and medical students, this provision includes PA and APRN students or other members of the medical teams, as individuals who are allowed to make notes in a patient’s medical record, and that are reviewed and verified by physicians, PA’s and APRNs.

Scope of Practice

For CY 2020, CMS is finalizing the “Physician Supervision for Physician Assistant (PA) Services” proposal, implementing CMS’ reinterpretation of Medicare law that requires physician supervision for PAs’ professional services.

Accordingly, Federal regulations at 42 CFR 410.74 (a)(2) require that PAs must furnish their professional services in accordance with State law, and State scope of practice rules for PAs that are specific for the State in which the services are furnished to the extent that those rules describe the required relationship between physicians and PAs, including its collaborative nature, and describe a form of supervision for Medicare’s purposes.

For States with no explicit State law and guidance regarding physician supervisions of PAs, physician supervision is a process with one or more physicians to supervise the delivery of their healthcare services. Such physician supervision is evidenced by documenting the PA’s scope of practice and indicating the working relationships the PA has with the supervising when furnishing professional services, with any required documentation of PA supervision maintained at the practice level, instead of in the medical record for each patient.

Chronic Care Management (CCM) Services

Non-Complex CCM

For non-complex CCM, Medicare is creating a Medicare-specific add-on code (G0208) to Current Procedural Terminology (CPT) code 99490; that you may use to report increments of 21-40 and, (if applicable) 41-60 minutes of clinical staff time of non-complex CCM services. You
can report this add-on code to CPT code 99490 a maximum of twice per service period. When you report G2058, CPT code 99490 will represent the first 20 minutes of non-complex CCM services, with G2058 reporting additional 20-minute increments of service time (maximum of 60 minutes total). Additional information on G2058 is as follows:

- **G2058**: Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure). (Do not report G2058 for care management services of less than 20 minutes additional to the first 20 minutes of Chronic Care Management services during a calendar month). (Use G2058 in conjunction with 99490). (Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491).

**CCM Typical Care Plan Revision**

For all CCM, CMS is finalizing revised language for the typical care plan that will apply for Medicare payment purposes. The new language reads: The comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers
- Requirements for periodic review
- When applicable, “revision of the care plan”

**For complex CCM (CPT codes 99487, 99489)**

CMS is providing that the care planning service element may be met when the care plan is established, implemented, revised, or monitored (rather than established or substantially revised).

**For Transitional Care Management (TCM) (CPT 99495-6)**

CMS is increasing payment by adopting the Relative Value Scale (RVS) Update Committee (RUC) recommended increases in valuation. CMS is also providing that 14 HCPCS codes currently not reportable during the same service period as TCM may be concurrently reported when medically necessary and not duplicative of other services. The codes are listed in table 20 in the final rule.

**Therapy**

In the CY 2019 MPFS final rule, in accordance with amendments to the Medicare law, CMS established modifiers to identify therapy services that are furnished in whole, or in part, by Physical Therapy (PT) and Occupational Therapy (OT) assistants, and set a de minimis 10 percent standard for when these modifiers will apply to specific services. CMS also established that the statutory reduced payment rate for therapy assistant services, effective beginning for services furnished in CY 2022, does not apply to services furnished by Critical Access Hospitals because they are not paid for therapy services at MPFS rates.

Beginning January 1, 2020, these modifiers are required by statute to be reported on claims. After consideration of public comments, CMS finalized that the assistant modifiers do not apply when a therapist and therapist assistant furnish services together, and, that in addition to untimed codes, CMS is allowing, for billing purposes, the application of the modifier to each 15-minute timed unit of such timed codes, instead of all the time units for that service on a given day.
Opioid Use Disorder Treatment Furnished by Opioid Treatment Programs (OTPs)

Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act established a new Medicare Part B benefit for Opioid Use Disorder (OUD) treatment services, including medications for Medication-Assisted Treatment (MAT), furnished by OTPs. To meet this statutory requirement, CMS is finalizing the definition of OUD treatment services which includes:

- Food and Drug Administration (FDA)-approved opioid agonist and antagonist treatment medications
- The dispensing and administering of such medications (if applicable)
- Substance use disorder counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments
  - The Substance Abuse and Mental Health Services Administration (SAMHSA) certification is required as part of the enrollment policy and process for OTPs. OTPs that received SAMHSA certification prior to October 24, 2018 will be deemed “moderate risk” while OTPs that received SAMHSA certification on or after October 24, 2018 will remain in the “high risk” screening level.
  - CMS is finalizing bundled payment rates for OTPs based on the medication administered and the intensity of services in order to account for differences in beneficiaries’ clinical needs. CMS finalized the period of an episode of care as one week in duration. The proposal to establish partial episodes was not finalized, based on public comment.
  - For the drug component of the OTP bundle, CMS finalized a payment of Average Sales Price (ASP)+0 percent, when ASP data are available. CMS also finalized an increased payment rate for the non-drug bundle payment rate and add-on codes for intact, periodic assessments and take-home dosing. For methadone, CMS will use TRICARE pricing when ASP is not reported. For oral buprenorphine, CMS is finalizing the use of National Average Drug Acquisition Cost pricing when ASP data are not reported; payment rates will be adjusted by geographic locality and adjustment on a yearly basis.
  - A policy to allow counseling and therapy services described in the bundled payments, to be furnished via two-way interactive audio-video communication technology as clinically appropriate
  - Zero beneficiary copayment for as long as there is a public health emergency to address the opioid crisis.

CMS is implementing this benefit beginning January 1, 2020, as required by the SUPPORT Act.

Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule

CMS is finalizing the creation of two new HCPCS codes, G2082 and G2083, effective January 1, 2020 on an interim final basis. This will allow for payment under the PFS for use of esketamine in services to patients with treatment-resistant depression during CY 2020.

Insertion, Removal, and Removal and Insertion of Implantable Interstitial Glucose Sensor System (Category III CPT codes 0446T, 0447T, and 0448T)

Category III CPT codes 0446T, 0447T, and 0448T describe services related to the insertion and removal of an implantable interstitial glucose sensor system, which are currently contractor priced, and will remain contractor priced in CY 2020. Given the immediate needs of Medicare beneficiaries with diabetes, including some who could benefit from the use of innovative technologies, we are seeking information from stakeholders to ensure proper payment for this
important physician’s service by establishing national payment rates in future rulemaking for the
insertion, removal, and removal and insertion of implantable interstitial glucose sensor system.

Long-Term EEG Monitoring Codes
CMS is finalizing for CY 2020 CPT codes 95700-95716 as contractor-priced. The rates are
established by regional MACs) in their respective jurisdictions.

Notes:
1. Your MACs will continue to use the codes identified in CR 9250 for the CT modifier
   reduction. You can find the associated MLN Matters article (MM9250) at https://
   www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/
   MLNMattersArticles/Downloads/MM9250.pdf.
2. Your MACs will use the prolonged preventive services G0513 and G0514 as an add-
   on to the covered preventive services located on the CMS website at https://www.cms.
   gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-
   Preventive-Services.html

ADDITIONAL INFORMATION
The official instruction, CR 11560, issued to your MAC regarding this change is available at

If you have questions, your MACs may have more information. Find their website

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at
1.877.299.4500 and choose Option 1.

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FOR HOME HEALTH AND HOSPICE PROVIDERS

MM11570: CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) issued the following Medicare Learning
Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on
the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/
MLNMattersArticles/index

MLN Matters Number: MM11570
Related CR Release Date: December 6, 2019
Related CR Transmittal Number: R4470CP
Related Change Request (CR) Number: 11570
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

PROVIDER TYPES AFFECTED
This MLN Matters Article is intended for providers and suppliers submitting claims to Medicare
Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics
and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule provided to
Medicare beneficiaries.
PROVIDER ACTION NEEDED

Change Request (CR) 11570 provides the Calendar Year (CY) 2020 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. Payment on a fee schedule basis is required for certain Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834 (a), (h), and (i) of the Social Security Act (the Act). Additionally, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts, and Intraocular Lenses (IOLs) inserted in a physician’s office. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to fee schedule adjustments using information on the payment determined for these items under the DMEPOS Competitive Bidding Program (CBP), as well as codes that are not subject to the CBP or fee schedule adjustments.

Fee Schedule Adjustment Methodologies

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for DME items included in the CBP for payment of the items in areas that are not competitive bidding areas (CBAs). Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (ental nutrition) based on information from the CBP.

The methodologies for adjusting DMEPOS fee schedule amounts using information from the CBP are in regulations at 42 CFR Section 414.210(g). The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts, as well as codes that are not subject to the fee schedule CBP adjustments. Recent program instructions on these fee schedule adjustments are available in Transmittal 4209, CR 11064, January 18, 2019 at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11064.pdf

For CY 2020, the following applicable Fee Schedule Adjustment Methodologies and fee schedule amounts reflect the area in which the items and services are furnished.

1. Fee Schedule Amounts for Areas within the Contiguous United States

For claims with dates of service from January 1, 2019, through December 31, 2020, the adjusted fee schedule amounts for items furnished in non-competitively bid rural areas are a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amount for the item, which is updated by the covered item updates specified in Sections 1834(a)(14) and 1842(s)(B) of the Act, for DME and enteral nutrition respectively. For claims with dates of service from January 1, 2019, through December 31, 2020, the adjusted fee schedule amounts for items furnished in other non-competitively bid areas are based on 100 percent of the adjusted fee schedule amounts.

To determine the adjusted fee schedule amounts, the average of the Single Payment Amounts (SPAs) from CBAs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These Regional SPAs or RSPAs are also subject to a national ceiling (110 percent of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90 percent of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most competitively bid DME items furnished in the contiguous United States, that is, those included in more than 10 CBAs. Fees schedule amounts for competitively bid DME items included in 10 or fewer CBAs adjust so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs.
Additionally, the fee schedule amounts for areas within the contiguous United States designated as rural areas adjust to equal the national ceiling amounts described above. Regulations at Section 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code estimated to be outside any Metropolitan Statistical Area (MSA). A rural area also includes any ZIP Code within an MSA excluded from a CBA established for that MSA.

The CBP and SPAs generated from the CBP that are used to adjust the fee schedule amounts expired on January 1, 2019. Pursuant to 42 CFR Section 414.210(g)(4), the adjusted fee schedule amounts are increased by 1.6 percent on January 1, 2020, based on the percentage change in the CPI for all Urban Consumers (CPI-U) for the 12-month period ending June 30, 2019.

2. Fee Schedule Amounts for Areas outside the Contiguous United States

Fee schedule amounts for items furnished in areas outside the contiguous United States (that is, noncontiguous areas such as Alaska, Guam, Hawaii) are based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amounts updated by the covered item updates specified in Sections 1834(a)(14) and 1842(s)(B) of the Act. Areas outside the contiguous United States receive adjusted fee schedule amounts so they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

For the CY January 1, 2020 fee schedule update, the adjusted fee schedule amounts in non-bid areas will receive a CPI-U update per Section 414.210(g) of 1.6 percent due to the adjustments being based on SPAs from competitive bidding programs that are no longer in effect.

**KE Modifier**

Because the rural and non-contiguous fee schedule amounts are based partially on unadjusted fee schedule amounts, fees for certain items included in the 2008 Original Round One CBP, denoted with the KE modifier, appear on the fee schedule file only for items furnished in rural and non-contiguous areas. Instructions and a list of the applicable KE HCPCS codes are available in Transmittal 1630, CR 6270, from November 7, 2008 (see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6270.pdf). From June 1, 2018, through December 31, 2020, the rural and non-contiguous KE fee schedule amounts will be based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted KE fee schedule amount updated by the covered item updates specified in Sections 1834(a)(14) and 1842(s)(B) of the Act. The non-rural fees for these KE codes contain zeros on the fee schedule file since KE is not a valid option for areas without blended fees.

For certain accessories used with base equipment included in the CBP in 2008 (for example, power wheelchairs, walkers, and negative pressure wound therapy pumps), the unadjusted fee schedule amounts include a 9.5 percent reduction in accordance with Federal law if these accessories were also included in the 2008 CBP. The 9.5 percent fee reduction only applies to these accessories when furnished for use with the base equipment included in the 2008 CBP. Beginning June 1, 2018, in cases where accessories included in the 2008 CBP are furnished for use with base equipment that was not included in the 2008 CBP (e.g., manual wheelchairs, canes and aspirators), for beneficiaries residing in rural or non-contiguous, non-competitive bid areas, suppliers should append the KE modifier to the HCPCS code for the accessory. Suppliers should not use the KE modifier with accessories that were included in the 2008 CBP and furnished for use with base equipment that was not included in the 2008 CBP when furnishing these accessories to beneficiaries residing in non-rural, non-competitive bid areas. The KE modifier is not billable for items furnished in former competitive bid areas effective January 1, 2019 (see payment methodology below).
The Round 2 Recompete, National Mail-Order Recompete, and Round 1 2017 contract periods of performance expired December 31, 2018. Due to a delay, contracts will not be in effect January 1, 2019 – December 31, 2020, resulting in a gap in the CBP. During the gap period in the DMEPOS CBP, any Medicare enrolled DMEPOS supplier may furnish any DMEPOS item, including items that were formerly included in the CBP. In addition, payment for all items and services that were included in the CBP are based on the lower of the supplier’s charge for the item or fee schedule amounts adjusted in accordance with Sections 1834(a)(1)(F) and 1842(s)(3)(B) of the Social Security Act. The fee schedules for items and services furnished in former CBAs are based on the SPAs in effect in the CBA on the last day before the CBP contract period of performance ended, increased by the projected percentage change in the CPI-U for the 12-month period on the date after the contract periods ended.

The fee schedule amounts increase once every 12 months on the anniversary date of the first day after the contract period ended with the CPI-U. For CY 2019, the fee schedule amounts for items furnished in areas that were CBAs as of December 31, 2018, adjust based on the Single Payment Amounts (SPAs) for each specific CBA, increased by the projected percentage change in the CPI-U of 2.5 percent for the 12-month period ending January 1, 2019. For CY 2020, the adjusted fee schedule amounts increase by the projected percentage change in the CPI-U of 2.4 percent for the 12-month period ending January 1, 2020.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment that applies for codes with rural and non-rural adjusted fee schedule amounts. The DMEPOS Rural ZIP code file contains the ZIP codes designated as rural areas. ZIP codes for non-continental MSA are not included in the DMEPOS Rural ZIP code file. The update to the DMEPOS Rural ZIP code file occurs on a quarterly basis as necessary. Regulations at Section 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is outside any MSA. A rural area also includes any ZIP Code within an MSA excluded from a competitive bidding area established for that MSA.

The ZIP code associated with the permanent address of the beneficiary determines applicability of the adjusted fee schedule amounts in former CBAs. During a gap in the CBP, a former CBA ZIP code file will contain the ZIP codes and the update will occur on a quarterly basis as necessary.

The following CY 2020 DMEPOS fee schedule and ZIP code Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the above files on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

1. DMEPOS Fee schedule PUF
2. DME PEN Fee schedule PUF
3. DMEPOS Rural ZIP code PUF
4. Former CBA Fee schedule PUF
5. Former CBA National Mail Order diabetic testing supply fee schedule PUF
6. Former CBA ZIP Code PUF

**Regulations for Pricing New DMEPOS Items**

Effective January 1, 2020, regulations on methodologies for establishing fees for new DMEPOS items are published in the CY 2020 End-Stage Renal Disease (ESRD)/ DMEPOS final rule, CMS-1713-F, which is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-
CR 11570 KEY POINTS

New Codes Added

New DMEPOS codes added to the HCPCS file are effective January 1, 2020, where applicable. You cannot use the new codes for billing until they are effective on January 1, 2020.

The HCPCS codes listed below are being added to the HCPCS effective January 1, 2020. The Common Working File (CWF) will add the following categories (in parentheses) and payment categories to its system as follows:

1. A4226 (60)  5. K1001 (60)  9. K1005 (60)
2. B4187 (09, 60) PEN  6. K1002 (60)  10. L2006 (60)
3. E0787 (60)  7. K1003 (60)  11. L8033 (03,60) PO
4. E2398 (60)  8. K1004 (67)

There are no fees added to the DMEPOS fee schedule file for new HCPCS codes effective January 1, 2020. The Medicare coverage and payment determinations for these items are made based on the discretion of the DME MACs and A/B MACs Part B processing claims for these items, until national Medicare coverage and payment guidelines have been established for these codes. The DME MACs and A/B MACs Part B will establish local fee schedule amounts to pay claims for the new codes when applicable, and pay in accordance with the payment rules associated with each payment determination (for example, an item determined to be an expensive item of DME that is reasonable and necessary and not otherwise excluded from coverage by statute, regulations, an National Coverage Determination (NCD) or program instructions, must be paid on a capped rental basis in accordance with regulations at CFR 414.229).

Gap-Filled DMEPOS Fees

Fee schedule amounts for new HCPCS codes for items and services without a fee schedule pricing history are established using existing fee schedule amounts for comparable items when items with existing fee schedule amounts are determined to be comparable to the new items and services. CR 11570 also makes changes to the gap-fill and continuity of pricing instructions in Chapter 23, Sections 60.3 and 60.3.1 of the "Medicare Claims Processing Manual."

For gap filling pricing purposes, before updating to the current year deflation factors apply. The deflation factors to apply to 2019 price information by payment category are:

- 0.427 for Oxygen
- 0.430 for Capped Rental
- 0.431 for Prosthetics and Orthotics
- 0.547 for Surgical Dressings
- 0.595 for Parental and Enteral Nutrition
- 0.912 for Splints and Casts
- 0.896 for Intraocular Lenses

Codes Deleted

Effective January 1, 2020, there are no deleted HCPCS codes from the DMEPOS fee schedule.

Therapeutic Shoe Modification Codes

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data.

Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513).
The base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004 to establish the fee schedule amounts for the shoe modification codes.

For 2020, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. For 2020, CMS weights the base fees for A5512 and A5513 based on the approximated total allowed services for each code for items furnished during the calendar year 2018. The revised fee schedule amounts for shoe modification codes A5503 through A5507 will reflect this change, effective January 1, 2020.

**Diabetic Testing Supplies**

The fee schedule amounts for non-mail order Diabetic Testing Supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are not updated by the annual covered item update. In accordance with Section 1834(a)(1)(H) of the Act, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the SPAs for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act. Initial program instructions on these fees are available in Transmittal 2709, CR 8325, dated May 17, 2013 (see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf and Transmittal 2661, CR 8204, dated February 22, 2013 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf). The National Mail-Order Recompete DTS SPAs are available at the following website: https://www.dmecontractorbid.com/palmetto/cbic.nsf/DocsCat/Home.

The non-mail order DTS amounts on the fee schedule update each time there is an update to the single payment amounts. This can happen no less often than every time the mail order CBP contracts are recompeted. The National Mail Order Recompete CBP for mail order diabetic supplies was effective July 1, 2016, to December 31, 2018. As of January 1, 2020, payment for non-mail order diabetic supplies at the National Mail Order Recompete SPAs will continue in accordance with Section 1834(a)(1)(H) of the Act and these rates will remain in effect until new SPA rates are established under the national mail order program.

Effective January 1, 2020, there is an adjustment to the fee schedule amounts for mail order DTS (with KL modifier) using the methodology for areas that were formerly CBAs during periods when there is a temporary lapse in the CBP. The National Mail-Order Recompete DTS SPAs of December 31, 2018, are increased by the projected percentage change in the CPI-U for the 12-month period on the date after the contract periods ended.

The fee schedule amounts increase once every 12 months on the anniversary date of the first day after the contract period ended with the CPI-U. For dates of service between January 1, 2019, and December 31, 2019, the National Mail-Order Recompete SPAs change by the projected rate of 2.5 percent. For CY 2020, the adjusted CY 2019 mail order DTS updated fees change by the projected percentage change in the CPI-U of 2.4 percent for the 12-month period ending January 1, 2020. The national mail order adjusted fee schedule amounts will be used in paying mail order diabetic testing supply claims in all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and the American Samoa.

**2020 Fee Schedule Update Factor of 0.9 Percent**

For CY 2020, an update factor of 0.9 percent applies to certain DMEPOS fee schedule amounts. Fee schedule amounts that are adjusted using information from CBPs are not subject to the annual DMEPOS covered item update, but updated pursuant to the applicable adjustment methodologies outlined in 42 CFR Section 414.210(g).

In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts change for 2020 by the percentage increase in the CPI for all urban consumers (United States city average). The CPI-U for the 12-month period ending June 30, 2019, adjusts due to
the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.7 percent and the CPI-U percentage increase is 1.6 percent. Thus, the 1.6 percentage increase in the CPI-U decreases by 0.7 percentage increase in the MFP - a net increase of 0.9 percent for the update factor.

2020 Oxygen and Oxygen Equipment Fee Schedule Amounts

Consistent with the requirements set forth in Section 1834(a)(9)(D)(ii) of the Act, a budget neutrality offset must be applied to all oxygen payment classes and items including:

- Stationary oxygen equipment and oxygen contents (E0424, E0439, E1390, and E1391)
- Portable oxygen equipment add-on (E0431 and E0434)
- OGPE add-on (E0433, E1392, and K0738)
- Stationary contents (E0441 and E0442)
- Portable contents (E0443 and E0444) and
- Portable liquid contents for high flow patients (E0447)

For CY 2020, the offset percentage varies by geographic area and ranges from 7 to 10 percent in areas that are not former CBAs.

2020 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment


To summarize, payment for maintenance and servicing of certain oxygen equipment can occur:

- Every 6 months beginning 6 months after the end of the 36th month of continuous use, or
- End of the supplier’s or manufacturer’s warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the “MS” modifier

Payment can occur only once per beneficiary, for any 6-month period, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary.

Per 42 CFR Section 414.210(e)(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2019 maintenance and servicing fee is adjusted by the 0.9 percent MFP-adjusted covered item update factor to yield a CY 2020 maintenance and servicing fee of $73.02 for oxygen concentrators and transfilling equipment.

2020 Update to the Labor Payment Rates

Included in Attachment A are the CY 2020 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI for all urban consumers (CPI-U) for the twelve-month period ending with June 30, 2019, is 1.6 percent, this change applies to the 2020 labor payment amounts to update the rates for CY 2020.

The 2020 labor payment amounts in the Table 1 (Attachment A in CR 11570) are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2020 through December 31, 2020.
Table 1: 2020 Labor Payment Amounts

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ADDITIONAL INFORMATION
The official instruction, CR11570, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r4470cp.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

DOCUMENT HISTORY

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<th>Description</th>
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<td>December 9, 2019</td>
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FOR HOME HEALTH AND HOSPICE PROVIDERS

Provider Contact Center (PCC) Training

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to
offer training to our customer service representatives (CSRs). The list below indicates when the home health and hospice PCC at 1.877.299.4500 (option 1) will be closed for training.

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The Interactive Voice Response (IVR) (1.877.220.6289) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at [https://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf](https://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf) on the CGS website. In addition, CGS’ Internet portal, myCGS, is available to access eligibility information through the Internet. For additional information, go to [https://www.cgsmedicare.com/hhh/index.html](https://www.cgsmedicare.com/hhh/index.html) and click the “myCGS” button on the left side of the webpage.


### FOR HOME HEALTH AND HOSPICE PROVIDERS

**SE19029 (Revised):** Medicare Part B Home Infusion Therapy Services With The Use Of Durable Medical Equipment

The Centers for Medicare & Medicaid Services (CMS) revised the following *Special Edition Medicare Learning Network® (MLN) Matters* article. This MLN Matters article and other CMS articles can be found on the CMS website at: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index)

**MLN Matters Number:** SE19029 Revised

**Article Release Date:** December 13, 2019

**Related CR Transmittal Number:** N/A

**Effective Date:** N/A

**Implementation Date:** N/A

**NOTE:** We revised this article on December 13, 2019, to correct footnote 5 on page 7 which should have stated J code, J1559, instead of J1159. The article release date was also changed. All other information is unchanged.

### PROVIDER TYPES AFFECTED

This special MLN Matters® Article is intended for entities seeking accreditation to become qualified suppliers that furnish home infusion therapy (HIT) services in coordination with the furnishing of home infusion drugs administered through an item of durable medical equipment (DME) beginning in calendar year 2021 and in subsequent years.

### BACKGROUND

Section 1834(u)(1) of the Social Security Act (the Act), as added by Section 5012 of the 21st Century Cures Act (Pub. L. 144-255), established a new Medicare HIT benefit under Medicare Part B. The Medicare HIT benefit is for coverage of HIT services for certain drugs and biologicals administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual, through a pump that is a DME item. This benefit is effective January 1, 2021.

For more information regarding services furnished in calendar years 2019 and 2020, review the Home Infusion Therapy Temporary Transitional Payment Frequently Asked Questions (FAQ) at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Downloads/Home-Infusion-Therapy-Services-Temp-Transitional-Payment-FAQs.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Downloads/Home-Infusion-Therapy-Services-Temp-Transitional-Payment-FAQs.pdf).
Section 1861(iii)(D)(i) of the Act defines a qualified HIT supplier as a pharmacy, physician, or other provider of services or supplier licensed by the State in which the pharmacy, physician, or provider of services or supplier furnishes items or services and that—

I. Furnishes infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs;

II. Ensures the safe and effective provision and administration of home infusion therapy on a 7-day-a-week, 24-hour-a-day basis;

III. Is accredited by an organization designated by the Secretary pursuant to section 1834(u)(5); and

IV. Meets such other requirements as the Secretary determines appropriate.

A qualified home infusion therapy supplier may subcontract with a pharmacy, physician, provider of services, or supplier to meet the requirements listed above.

WHAT YOU NEED TO KNOW

HIT involves the parenteral administration of drugs or biologicals to an individual at home, outside of the hospital or clinic setting. There are a variety of items and services involved in home infusion in order to ensure that therapy is safe and effective in the home. In general, as shown in Figure 1, HIT consists of four components:

1. The infusion drug (covered under the DME benefit as a supply necessary for the effective use of an infusion pump covered under the DME benefit),

2. The external infusion pump and related equipment (for example, an IV pole),

3. Supplies other than the drug (for example, tubing and catheters), and

4. Professional services, such as nurse visits.

Medicare ensures coverage of these components through a combination of benefit categories:

The DME benefit covers three components: the external infusion pump, the related supplies, and the infusion drug. Additionally, this benefit covers the related services required to furnish these items (e.g., pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items) by an eligible DME supplier. No payment is made under the HIT benefit for these DME items and services.

The new HIT benefit covers the service component, meaning the professional services, training and education (not otherwise covered under the DME benefit), and monitoring furnished by a qualified HIT supplier needed to administer the home infusion drug in the patient’s home.

It is important to note that certain drugs are only covered under Part B of the Medicare program, either incident to a physician’s professional service, as a DME supply, or in specific cases, such
as immunosuppressive drugs, oral anti-cancer drugs, oral anti-emetic drugs, erythropoietin for dialysis patients, and intravenous immune globulin. Drugs administered through infusion pumps are covered with the pump under the DME benefit as supplies necessary for the effective use of the DME (infusion pump) and listed on the DME LCD for External Infusion Pumps\(^1\).

To be eligible for coverage under the DME benefit, the pump and drug must be appropriate for use by the patient and/or caregiver in the patient’s home and it must be medically necessary to use the pump to administer the drug. To be eligible for coverage of services under the HIT benefit, an individual must be receiving an intravenous or subcutaneous drug or biological included on the DME LCD for External Infusion Pumps, with the exception of insulin pump systems and any drugs included on a self-administered drug (SAD) exclusion list.

Section 1834(u)(1)(A)(ii) of the Act states that payment is for an “infusion drug administration calendar day” in the individual’s home, and refers to payment only for the date on which professional services were furnished to administer such drugs to such individual. In the CY 2019 Medicare Home Health Prospective Payment System final rule (83 FR 56583), CMS stated in regulation that payment for an “infusion drug administration calendar day,” is for the day on which home infusion therapy services are furnished by skilled professionals in the individual’s home on a day of infusion drug administration. The skilled services provided on such day must be so inherently complex that they can only be safely and effectively performed by, or under the supervision of, professional or technical personnel (42 CFR 486.505). The payment amount for an “infusion drug administration calendar day” covers the cost of services furnished in coordination with the administration of home infusion drugs in the patient’s home. These services include: professional services, including nursing; training and education (not otherwise paid for under the Medicare Part B DME benefit); and monitoring and remote monitoring services.

Qualified HIT suppliers can only bill and be paid for the HIT services furnished on the day on which a professional is physically present in the patient’s home and an infusion drug is being administered on such day. Medicare payment for an infusion drug administration calendar day is separate from the payment for DME items and services, therefore, a supplier could still be paid for DME items and services under the DME benefit, even if the supplier does not receive payment for home infusion therapy services under the HIT benefit. The HIT single payment amount does not include payment for the DME external infusion pump, supplies (including the home infusion drug), and related services paid under the DME benefit. The HIT single payment is instead intended to cover the monitoring and other professional services that occur in the patient’s home (and that are not for the set-up and training on the routine use of the external infusion pump). The external infusion pump, supplies, and the infusion drug continue to be covered in accordance with DME policies regardless of when and how often a skilled professional is in the individual’s home to provide home infusion therapy services.

**Home Infusion Items and Services Furnished Under the DME Benefit**

Under the DME benefit, suppliers bill for external infusion pumps covered as DME and supplies (for example, intravenous catheter supplies and infusion drugs). DME payment for these items includes the related services required to furnish these items (for example, intake and assessment, delivery and set-up, training, pharmacy services, and follow-up). Under this benefit, the supplier is required to consult with the prescribing physician, as needed, to confirm the order and to recommend any necessary changes, refinements, or additional evaluations to the prescribed equipment, item(s), and/or service(s). This includes reviewing the beneficiary’s record as appropriate and incorporating any pertinent information related to the beneficiary’s condition(s) which affect the provision of the DME and related services, or to the actual equipment, item(s) and service(s) provided, in collaboration with the prescribing physician; and maintaining the prescription, any certificates of medical necessity (CMNs), and pertinent documentation from the beneficiary’s prescribing physician in the beneficiary’s record\(^2\).

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The DME supplier is also responsible for delivery and set up of the equipment, as well as training and education on operation of the infusion pump. According to the DMEPOS Quality Standards, supplier responsibilities include: providing relevant and appropriate information related to the set-up, routine use, cleaning, troubleshooting, infection control practices, and maintenance of the equipment and supplies; documenting in the patient’s record that the patient and/or caregiver has received training and written instructions on the use of equipment and supplies; and ensuring the patient and/or caregiver can use all equipment and supplies safely and effectively.

The DME benefit also covers pharmacy services (i.e., drug preparation and dispensing), including sterile compounding, that are associated with the furnishing of the home infusion drug. Section 1861(iii)(3)(C) defines a home infusion drug as a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of DME, but does not include insulin pump systems or a self-administered drug or biological on a self-administered drug exclusion list. External infusion pumps are covered under the DME benefit, and drugs used in conjunction with a covered pump are considered supply items for the pump and eligible for reimbursement on that basis. Specifically, in accordance with the DMEPOS Supplier Standards, a supplier that furnishes a drug used as a Medicare-covered supply with durable medical equipment or prosthetic devices must be licensed by the State to dispense drugs.

In general, the Medicare allowed payment amount for an item or service is payment for furnishing that item or service and includes payment for everything involved in, and necessary for furnishing that item or service. For example, supply code A4222 includes the cassette or bag, diluting solutions, tubing and other administration supplies, port cap changes, as well as compounding charges and preparation charges.

**Home Infusion Therapy Services Furnished Under the HIT Benefit**

The HIT benefit is intended to be a separate payment from the amount paid under the DME benefit, explicitly covering the professional services that occur in the patient’s home (and that are not for the set-up and training on the routine use of the external infusion pump), as well as monitoring and remote monitoring services for the provision of home infusion drugs. Home infusion drugs are defined as parenteral drugs and biologicals administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of DME covered under the Medicare Part B DME benefit. The HIT benefit covers services distinct from those under the DME benefit (as discussed above) and could conceivably include, for example:

- Training and education on care and maintenance of vascular access devices:
  - Hygiene education
  - Instruction on what to do in the event of a dislodgement or occlusion
  - Education on signs and symptoms of infection
  - Teaching and training on flushing and locking the catheter
- Dressing changes and site care
- Patient assessment and evaluation:
  - Review history and assess current physical and mental status, including obtaining vital signs
  - Assess any adverse effects or infusion complications
  - Evaluate family and caregiver support
  - Review prescribed treatment and any concurrent oral and/or over-the-counter treatments
  - Obtain blood for lab-work

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3 ibid
4 https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DMEPOSSupplierStandards.pdf
Medication and disease management education:
- Instruction on self-monitoring
- Education on lifestyle and nutritional modifications
- Education regarding drug mechanism of action, side effects, interactions with other medications, adverse and infusion-related reactions
- Education regarding therapy goals and progress
- Instruction on administering pre-medications and inspection of medication prior to use
- Education regarding household and contact precautions and/or spills

Monitoring/remote monitoring services:
- Communicate with patient and physician regarding changes in condition and treatment plan
- Monitor patient response to therapy
- Assess compliance

Qualified HIT suppliers can only bill for HIT for days on which a professional is physically present in the patient’s home and an infusion drug is being administered. This means that, although remote monitoring is covered under the HIT benefit, the supplier can only bill for services that are furnished when a skilled professional is in the patient’s home on an “infusion drug administration calendar day.” Any services furnished that do not occur on an “infusion drug administration calendar day” are built into the single payment for the days on which the skilled professional is in the patient’s home and the drug is being infused.

Table 1: Benefit Categories and Codes for Home Infusion Therapy Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Item/Service</th>
<th>Codes</th>
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<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td>Home Infusion Drug External Infusion Pump Medical Supplies</td>
<td>J-codes&lt;sup&gt;5&lt;/sup&gt; E0779, E0781, E0791, E0780, K0455 A4221, A4222, K0552, A4602, K0604, K0605</td>
</tr>
<tr>
<td>Home Infusion Therapy (HIT)</td>
<td>In-Home Professional Services:</td>
<td>G0068 (for other intravenous drugs), G0069 (for subcutaneous drugs), G0070 (for chemotherapy drugs)</td>
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<td></td>
<td>- Training and Education (not included under DME benefit); and Professional Services, Including Nursing Care (e.g., dressing changes and site care) Monitoring and Remote Monitoring Services (bundled into the payment amount for the professional services visit)</td>
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</tbody>
</table>

ACCREDITATION FOR HOME INFUSION THERAPY

A qualified home infusion supplier must be accredited by a CMS approved accreditation organization prior to providing services under the HIT benefit. To locate or inquire about an approved accreditation organization, you may submit a question to the CMS HIT Accreditation mailbox at HITaccreditation@cms.hhs.gov.

ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

<sup>5</sup> A list of qualified J-codes is found in the HIT Temporary Transitional Payment Frequently FAQ document at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Downloads/Home-Infusion-Therapy-Services-Temp-Transitional-Payment-FAQs.pdf. Please note that J2274, J2278, J1659, and J9200 are not covered under the HIT benefit beginning CY 2021.
FOR HOME HEALTH AND HOSPICE PROVIDERS

Upcoming Educational Events

The CGS Provider Outreach and Education (POE) department offers educational events through webinars and teleconferences throughout the year. Registration for these events is required. For upcoming events, please refer to the Calendar of Events Home Health & Hospice Education Web page at https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/HHH_Report.asp. CGS suggests that you bookmark this page and visit it often for the latest educational opportunities.

If you have a topic that you would like the CGS POE department to present, send us your suggestion to J15_HHH_Education@cgsadmin.com.

FOR HOME HEALTH AND HOSPICE PROVIDERS

Update to the Interest Paid on Clean Non-PIP Claims Not Paid Timely

According to the Medicare Claims Processing Manual, (Pub 100-04, Ch. 1., §80.2.2), interest is paid on clean claims, not paid under the periodic interim payment (PIP) method, if payment is not made within 30 days after the date of receipt. The interest rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. Effective, January 1, 2020, the interest amount is 2.125%.

For additional information about when interest is paid on a claim, and how to calculate the interest, refer to the Medicare Claims Processing Manual, (Pub 100-04, Ch. 1., §80.2.2) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf on the Centers for Medicare & Medicaid Services (CMS) website. Current and past interest rate amounts can be viewed at https://fiscal.treasury.gov/prompt-payment/rates.html on the Treasury Department website.

TEST YOUR KNOWLEDGE AND EARN CREDIT!

https://www.surveymonkey.com/r/GYD85X6

Do you need to earn education credit? Launch the “Test your Knowledge” exercise! Correctly answer eight of ten questions based on this month’s Medicare Bulletin to earn a certificate that may be used to obtain education credit through coding and/or specialty societies. Good luck!