**KENTUCKY & OHIO**

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**A Valuable Educational Resource!**


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Contact Information for CGS Medicare Part B Providers

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.866.276.9558. Listen carefully and choose the option most appropriate for the reason you are calling.

- 1 - Claims
- 2 – Electronic Data Interchange (EDI)
- 3 – Provider Enrollment
- 4 - Telephone Reopening
- 5 – Overpayment Recovery (OPR)
- 9 – General Inquiries

For additional contact information, please access the Kentucky & Ohio Part B “Contact Information” web page at https://www.cgsmedicare.com/partb/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/partb/cs/howdoi.html) from the Jurisdiction 15 Part B Contact Information page at https://www.cgsmedicare.com/partb/cs/index.html. In addition, refer to the “Education & Resources Options” icon (https://www.cgsmedicare.com/partb/education/index.html) to access resources that may be able to answer your question.

CGS is Retiring Policy L34093 Chemotherapy and Biologicals

CGS will be retiring policy L34093 Chemotherapy and Biologicals effective June 7, 2020. This policy is being replaced with article A58113 Off-Label Use of Anti-Cancer Drugs and Biologicals that becomes effective on June 8, 2020.

We wanted to let the provider community know of this change prior to being implemented as this is a change from how we currently handle chemotherapy and biological drugs. While there will no longer be a local policy in place with attached billing and coding articles, we will be using the coverage indications as listed in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) 100-02, Chapter 15, section 50.4.1 and 50.4.5 which is the basis for the current policy. CGS will cover these types of drugs based on FDA label indications and for off label use if listed in one of the five CMS approved compendia’s (NCCN, Micromedex Drug DEX, Lexi-Drugs, AHFS, or Clinical Pharmacology).

CGS will also review and consider other off label use requests that are not listed as supported/recommended in one of the compendia’s if the use is supported by clinical research identified in CMS IOM 100-02, Chapter 15, section 50.4.5. When submitting a request for off label use not currently listed in a compendium please submit full articles.

CGS will be hosting a webinar on these changes on May 7, 2020 and encourage providers to attend. Please watch for additional information on our Calendar of Events web page.

Related Information:

KENTUCKY & OHIO

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after February 1997 are available at no cost from our website at http://www.cgsmedicare.com. © 2020 Copyright, CGS Administrators, LLC.
KENTUCKY & OHIO

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 CGS Part B PCC (1.866.276.9558) will be closed for CSR training and staff development.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Training/Closures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday, June 11, 2020</td>
<td>PCC Closed, 9:00 a.m.– 11:00 a.m. Eastern Time</td>
</tr>
<tr>
<td>Thursday, June 25, 2020</td>
<td>PCC Closed, 9:00 a.m.– 11:00 a.m. Eastern Time</td>
</tr>
</tbody>
</table>

The Interactive Voice Response (IVR) (1.866.290.9481) 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/partb/cs/partb_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/partb/index.html and click the “myCGS” button on the left side of the web page.


KENTUCKY & OHIO

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 Part B Calendar of Events Home page at https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/partb/report/partb_report.aspx. 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_PartB_Education@cgsadmin.com.

KENTUCKY & OHIO

Introducing our New Mobile App: CGS Medicare!

CGS Medicare, any time, any place. A refreshed version of our app is here!

Our app has gotten a full makeover for 2020! We have launched a brand new version of our previous mobile app “CGS Go Mobile” with a completely new style and name. The features have also been revamped. Simply called CGS Medicare, here’s what the refreshed app offers:

- Fee Schedule
- LCDs/Policy Articles
- News & Publications
- Contact
We can’t wait for you to take advantage of the free CGS Medicare app, so you can bring our most helpful features with you, wherever you go. The app is available in the App Store and Google Play Store. Just search CGS Medicare to download!

For more information about the CGS Medicare App, visit the Part B website at https://www.cgsmedicare.com/partb/onlinetools/cgsmedicare.html

KENTUCKY & OHIO

MM11467 Revised: Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM11467 Revised
Related CR Transmittal Number: R10045CP
Effective Date: April 1, 2020
Related CR Release Date: April 10, 2020
Related Change Request (CR) Number: 11467
Implementation Date: April 6, 2020

Note: We revised this article on April 10, 2020, to reflect a revised Change Request (CR) 11467. CR 11467 was revised to update the Uniform Resource Locators (URLs) references (page 2 in this article) in Background Section in the CR. The CR release date, transmittal number and link to the transmittal were also changed. All other information remains the same. 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 services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11467 updates the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staff is aware of this update.

BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards. These standards were adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claims. Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry six (6) months for implementation of newly added or changed codes.

The codes sets are available at: https://nex12.org/index.php/codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the January/February 2020 committee meeting shall be posted on these sites on or about March 1, 2020.

The Centers for Medicare & Medicaid Services (CMS) will issue future updates to these codes as needed. MACs must update their claims systems to ensure the current version of these codes is used in their claim status responses. MAC and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as the retirement of previously used codes or newly created codes.
These code changes are to be used in the editing of all ASC X12 276 transactions processed on or after the date of implementation. These code changes are also to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 11467.

The MACs must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, including the ASC X12 276/277 Health Care Claim Status Request and Response. These contractors must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses. They must also use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Healthcare Claim Acknowledgments.

References in this CR to “277 responses” and “claim status responses” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

ADDITIONAL INFORMATION

The official instruction, CR11467, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10045cp.pdf.

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

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
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<tr>
<td>April 10, 2020</td>
<td>We revised this article to reflect a revised CR 11467. CR 11467 was revised to update the URL references in Background Section in the CR (page 2 in this article). The CR release date, transmittal number and link to the transmittal were also changed. All other information remains the same.</td>
</tr>
<tr>
<td>November 15, 2019</td>
<td>Initial article released.</td>
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KENTUCKY & OHIO

MM11489 Revised: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

<table>
<thead>
<tr>
<th>MLN Matters Number:</th>
<th>MM11489 Revised</th>
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<tr>
<td>Related CR Transmittal Number:</td>
<td>R10054CP</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>April 1, 2020</td>
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</table>

| Related CR Release Date: | April 16, 2020 |
| Related Change Request (CR) Number: | 11489 |
| Implementation Date: | April 6, 2020 |

Note: We revised this article on April 16, 2020, to reflect an updated Change Request (CR) 11489 that revised the WPC website address in the background section of the CR (page 2 in this article). 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 services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11489 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes and obtain the updated MREP and PC Print if they use that software.
BACKGROUND
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy requires that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1.

CR 11489 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. The Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. The SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date later than the implementation date specified in CR 11489, MACs must implement on the date specified on the WPC website https://nex12.org/index.php/codes.

A discrepancy between the dates may arise, as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR 11489, MACs and SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update (CR11252 with related article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11252.pdf).

ADDITIONAL INFORMATION
The official instruction, CR11489, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10054CP.pdf.

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

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TEST YOUR KNOWLEDGE AND EARN CREDIT!
[https://www.surveymonkey.com/r/WSCTJ8S](https://www.surveymonkey.com/r/WSCTJ8S)

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!
**MM11490 Revised: Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE**

**MLN Matters Number:** MM11490 Revised  
**Related CR Transmittal Number:** R10064CP  
**Effective Date:** April 1, 2020  
**Related CR Release Date:** April 23, 2020  
**Related Change Request (CR) Number:** 11490  
**Implementation Date:** April 6, 2020

**Note:** We revised this article on April 23, 2020, to reflect the revised CR11490 issued on April 23, 2020. The CR revision updated the WPC website address and the same change is made to this article. In the article, we also 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 services provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

This article informs you that MACs and Medicare's Shared System Maintainers (SSMs) updated systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform use of Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Claim Adjustment Group Code (CAGC) rule publication. These system updates are based on the CORE Code Combination List scheduled to be published on or about February 1, 2020. Make sure your billing staffs are aware of these updates.

**BACKGROUND**

The Department of Health & Human Services (HHS) adopted the Phase III CAQH CORE, EFT and ERA Operating Rule Set that was implemented on January 1, 2014 under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act (the Act) by adding Part C—Administrative Simplification—to Title XI of the Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

CR 11490 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2020. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2019. This will also include updates based on market-based review that CAQH CORE conducts once every 2 years to accommodate code combinations that are currently being used by health plans including Medicare, as the industry needs them.

**Note:** The Affordable Care Act mandates that all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four (4) business scenarios. Medicare can use any code combination if the business scenario is not one of the four (4) CORE defined business scenarios. With the four (4) CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

**ADDITIONAL INFORMATION**

The official instruction, CR 11490, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10064CP.pdf.

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

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**KENTUCKY & OHIO**

**MM11638 Revised:** Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

- **MLN Matters Number:** MM11638 Revised
- **Related CR Transmittal Number:** R10052CP
- **Effective Date:** July 1, 2020
- **Related CR Release Date:** April 15, 2020
- **Related Change Request (CR) Number:** 11638
- **Implementation Date:** July 6, 2020

**Note:** We revised this article on April 16, 2020, to reflect an updated Change Request (CR) 11638 that revised the WPC website address in the background section of the CR (page 2 in this article). 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 services provided to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

CR 11638 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes and obtain the updated MREP and PC Print versions if they use that software.

**BACKGROUND**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructs health plans to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that, as appropriate, CARCs and RARCs are required in the remittance advice and coordination of benefits transactions. CARCs and RARCs provide either...
supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the RARC/CARC code update schedule that results in publication three times per year, around March 1, July 1, and November 1.

CMS provides a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. The Medicare system maintainers have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. The maintainers must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date later than the implementation date specified in CR11638, MACs must implement on the date specified on the WPC website https://nex12.org/index.php/codes.

A discrepancy between dates may arise, as the WPC website is only updated three times per year and may not match the CMS release schedule. MACs and system maintainers must get the complete list for both CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update (CR11489).

ADDITIONAL INFORMATION

The official instruction, CR 11638, issued to your MAC regarding this change, is available at https://www.cms.gov/files/document/r10052CP.pdf.

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

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</tr>
<tr>
<td>February 24, 2020</td>
<td>Initial article released.</td>
</tr>
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KENTUCKY & OHIO

MM11661 Revised: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update

MLN Matters Number: MM11661 Revised
Related CR Transmittal Number: R10039CP
Effective Date: January 1, 2020
Related CR Release Date: April 6, 2020
Related Change Request (CR) Number: 11661
Implementation Date: April 6, 2020

Note: We revised this article to reflect the revised CR 11661, issued on April 6, to make MPFSDB file revisions for COVID-19. In the article, we added updates for codes G2023, G2024, 87635, 98966, 98967, 98968, 99441, 99442, and 99443 to the April 2020 MPFSDB update file. Also, 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 services provided to Medicare beneficiaries and reimbursed using the Medicare Physician Fee Schedule (MPFS).
This article informs you that the Centers for Medicare & Medicaid Services (CMS) issued payment files to the MACs based upon the 2020 MPFS Final Rule, published in the Federal register on November 15, 2019. CR 11661 amends those payment files. Make sure your billing staffs are aware of these changes.

BACKGROUND
Section 1848(c)(4) of the Social Security Act authorizes the Secretary of the Department of Health and Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians’ services. The updated payment files are effective for services you furnish between January 1, 2020 and December 31, 2020.

Summary of Changes for April 2020
Below is a summary of the changes for the April update to the 2020 MPFS. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2020.

1. The G codes listed in Table 1 are new codes, effective January 1, 2020.

<p>| Table 1: New Codes effective January 1, 2020 |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2168</td>
<td>Status indicator = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
<tr>
<td>G2169</td>
<td>Status indicator = E; there are no RVUs, payment policy indicators do not apply.</td>
</tr>
</tbody>
</table>

Note: For new codes, please refer to the following link for more information: [https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update](https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update)

2. The HCPCS codes listed in Table 2 have revisions to Relative Value Units, effective for dates of service on and after January 1, 2020.

<p>| Table 2: HCPCS Codes with Revisions to Relative Value Units |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0105</td>
<td>53</td>
<td>Non-Facility PE RVU change = 2.88, MP RVU change = 0.20</td>
</tr>
<tr>
<td>G0121</td>
<td>53</td>
<td>Non-Facility PE RVU change = 2.88, MP RVU change = 0.21</td>
</tr>
<tr>
<td>44388</td>
<td>53</td>
<td>Non-Facility PE RVU change = 2.79, MP RVU change = 0.20</td>
</tr>
<tr>
<td>45378</td>
<td>53</td>
<td>Non-Facility PE RVU change = 2.88, MP RVU change = 0.21</td>
</tr>
<tr>
<td>G2001</td>
<td></td>
<td>MP RVU change = 0.05</td>
</tr>
<tr>
<td>G2002</td>
<td></td>
<td>MP RVU change = 0.08</td>
</tr>
<tr>
<td>G2003</td>
<td></td>
<td>MP RVU change = 0.13</td>
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<td>G2004</td>
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<td>MP RVU change = 0.22</td>
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<td>G2005</td>
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<td>MP RVU change = 0.28</td>
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<td>G2006</td>
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<td>MP RVU change = 0.05</td>
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<td>G2007</td>
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<td>MP RVU change = 0.09</td>
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</tbody>
</table>

3. The HCPCS codes listed in Table 3 have been revised, effective for dates of service on and after January 21, 2020. Please see the following link for more information regarding these codes: [https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=295](https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=295)

<p>| Table 3: Revised HCPCS codes |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>20560</td>
<td>Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 1, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0</td>
</tr>
</tbody>
</table>
Table 3: Revised HCPCS codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>20561</td>
<td>Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 1, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0</td>
</tr>
<tr>
<td>97810</td>
<td>Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 1, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0</td>
</tr>
<tr>
<td>97811</td>
<td>Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 1, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0</td>
</tr>
<tr>
<td>97813</td>
<td>Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 1, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0</td>
</tr>
<tr>
<td>97814</td>
<td>Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 1, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0</td>
</tr>
</tbody>
</table>

The Relative Value Units (RVU) for these codes are listed below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Work RVU</th>
<th>Non Facility PE RVU</th>
<th>Facility PE RVU</th>
<th>MP RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>20560</td>
<td>0.32</td>
<td>0.39</td>
<td>0.12</td>
<td>0.03</td>
</tr>
<tr>
<td>20561</td>
<td>0.48</td>
<td>0.57</td>
<td>0.18</td>
<td>0.05</td>
</tr>
<tr>
<td>97810</td>
<td>0.60</td>
<td>0.40</td>
<td>0.23</td>
<td>0.05</td>
</tr>
<tr>
<td>97811</td>
<td>0.50</td>
<td>0.25</td>
<td>0.19</td>
<td>0.05</td>
</tr>
<tr>
<td>97813</td>
<td>0.65</td>
<td>0.47</td>
<td>0.25</td>
<td>0.05</td>
</tr>
<tr>
<td>97814</td>
<td>0.55</td>
<td>0.36</td>
<td>0.21</td>
<td>0.05</td>
</tr>
</tbody>
</table>

4. The G code listed in Table 4 is no longer valid on the MPFS effective for dates of service on and after April 01, 2020.

Table 4: G Code No Longer Valid

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1000</td>
<td>Status Change to I</td>
</tr>
</tbody>
</table>

5. The G codes listed in Table 5 are new codes, effective April 01, 2020. CR 11550 implemented these codes.

Table 5: New G Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1012</td>
<td>Status indicator = X, there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>G1013</td>
<td>Status indicator = X, there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>G1014</td>
<td>Status indicator = X, there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>G1015</td>
<td>Status indicator = X, there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>G1016</td>
<td>Status indicator = X, there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>G1017</td>
<td>Status indicator = X, there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>G1018</td>
<td>Status indicator = X, there are no RVUs, payment policy indicators do not apply</td>
</tr>
<tr>
<td>G1019</td>
<td>Status indicator = X, there are no RVUs, payment policy indicators do not apply</td>
</tr>
</tbody>
</table>


As part of the public health emergency for the 2019 Novel Coronavirus (COVID-19) pandemic, the following codes have been revised per guidance provided in the interim final rule with comment (IFC) entitled, Medicare Program and Medicaid Program; Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC), effective for dates of service March 1, 2020, and after.
CODE | ACTION
--- | ---
98966 | Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 0, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0
98967 | Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 0, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0
98968 | Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 0, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0
99441 | Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 0, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0
99442 | Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 0, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0
99443 | Status code indicator change = A, Multiple Procedure indicator = 0, Bilateral Surgery indicator = 0, Assistant at Surgery indicator = 0, Co-Surgeons indicator = 0, Team Surgeons indicator = 0, Professional/Technical Component indicator = 0

The RVUs for these codes are listed below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Work RVU</th>
<th>Non Facility PE RVU</th>
<th>Facility PE RVU</th>
<th>MP RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>98966</td>
<td>0.25</td>
<td>0.13</td>
<td>0.10</td>
<td>0.02</td>
</tr>
<tr>
<td>98967</td>
<td>0.50</td>
<td>0.23</td>
<td>0.19</td>
<td>0.05</td>
</tr>
<tr>
<td>98968</td>
<td>0.75</td>
<td>0.33</td>
<td>0.29</td>
<td>0.06</td>
</tr>
<tr>
<td>99441</td>
<td>0.25</td>
<td>0.13</td>
<td>0.10</td>
<td>0.02</td>
</tr>
<tr>
<td>99442</td>
<td>0.50</td>
<td>0.23</td>
<td>0.19</td>
<td>0.05</td>
</tr>
<tr>
<td>99443</td>
<td>0.75</td>
<td>0.33</td>
<td>0.29</td>
<td>0.06</td>
</tr>
</tbody>
</table>

The following new codes are effective March 1, 2020, and after. Please see CR 11681 for more information. A related MLN Matters article (MM11681) is available at [https://www.cms.gov/files/document/mm11681.pdf](https://www.cms.gov/files/document/mm11681.pdf).

- G2023 - Status indicator = X, there are no RVUs, payment policy indicators do not apply
- G2024 - Status indicator = X, there are no RVUs, payment policy indicators do not apply
- The following new code is effective March 13, 2020, and after. Please see CR 11681 for more information.
- 87635 - Status indicator = X, there are no RVUs, payment policy indicators do not apply

**ADDITIONAL INFORMATION**


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).

**DOCUMENT HISTORY**

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 14, 2020</td>
<td>We revised this article to reflect the revised CR 11661, issued on April 6, to make MPFSDB file revisions for COVID-19. In the article, we added updates for codes G2023, G2024, 87635, 98966, 98967, 99441, 99442, and 99443 to the April 2020 MPFSDB update file. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.</td>
</tr>
</tbody>
</table>
**MM11681 Revised: Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment**

**MLN Matters Number:** MM11681 Revised  
**Related CR Transmittal Number:** R10033CP  
**Effective Date:** April 1, 2020  
**Related CR Release Date:** April 3, 2020  
**Related Change Request (CR) Number:** 11681  
**Implementation Date:** April 6, 2020

**Note:** We revised this article on April 6, 2020, to reflect revisions to CR11681. The CR revisions added code 87635 to the HCPCS file, effective March 13, 2020, added two new COVID-19 test codes (G2023 and G2024), effective March 1, 2020, and removed the section on the delay of the CLFS reporting period. This revised article reflects these revisions. Also, 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, other providers, and suppliers submitting clinical laboratory claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**
CR 11681 informs MACs about the changes in the April 2020 quarterly update to the Clinical Laboratory Fee Schedule (CLFS). Make sure that your billing staffs are aware of these changes.

**BACKGROUND**

**Advanced Diagnostic Laboratory Tests (ADLTs)**

Please refer to the following CMS website for additional information regarding these tests: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html#ADLT_tests.

**Fee Schedule Beginning January 1, 2018**

Effective January 1, 2018, CLFS rates will be based on weighted median private payor rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, see the PAMA Regulations, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html.

The Part B deductible and coinsurance do not apply for services paid under the CLFS.

**Access to Data File**

The quarterly clinical laboratory fee schedule data file shall be retrieved electronically through CMS’ mainframe telecommunications system. Under normal circumstances, CMS will make the updated CLFS data file available to the MACs approximately 6 weeks prior to the beginning of each quarter. For example, the updated file will typically be made available for download and testing on or before approximately February 15th for the April 1st release. Internet access to the quarterly clinical laboratory fee schedule data file will be available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United States Department of Defense, and other Federal agencies requesting access to the CLFS data file may contact the CMS National Offender Database Helpdesk at 1-800-776-0322.

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters issued after February 1997 are available at no cost from our website at http://www.cgsmedicare.com. © 2020 Copyright, CGS Administrators, LLC.
Mine Workers, and the Railroad Retirement Board, shall use the Internet to retrieve the quarterly CLFS. It will be available in multiple formats: Excel, text, and comma delimited.

**Pricing Information**

The CLFS includes separately payable fees for certain specimen collection methods (Healthcare Common Procedure Coding System (HCPCS) codes 36415, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Act.

The initial pricing for the new codes U0001 and U0002 for the Center for Disease Control and Prevention (CDC) test will be about $36 and non-CDC tests will be initially priced around $51, respectively. These prices may vary slightly depending on the local Medicare Administrative Contractor (MAC). View the full price by MAC list at: [https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf](https://www.cms.gov/files/document/mac-covid-19-test-pricing.pdf)

**New Codes Effective February 4, 2020**

The following new codes are added to the national HCPCS file with an effective date of February 4, 2020, and does not need to be manually added to the HCPCS files by the MACs. However, this new code is contractor-priced until it is addressed at the annual Clinical Laboratory Public Meeting, which will take place in June or July 2020, as it was received after the 2019 public meeting.

- Code: U0001
  - Short Descriptor: 2019 –nCoV diagnostic P
  - Type of Service (TOS): 5

- Code: U0002
  - Short Descriptor: COVID-19 lab test non-CDC
  - Long Descriptor: 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC
  - TOS: 5

**New Codes Effective March 1, 2020**

Medicare covers medically necessary and reasonable clinical diagnostic laboratory tests when ordered by a physician or non-physician practitioner who is treating the patient. As part of the Public Health Emergency for the COVID-19 pandemic and in efforts to be as expansive as possible within the current authorities to have testing available to Medicare beneficiaries who need it, the following codes are being priced under the CLFS per guidance provided in the interim final rule with comment (IFC) entitled, Medicare Program and Medicaid Program; Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC). The codes will be added to the national HCPCS file with an effective date of March 1, 2020.

- Code: G2023
  - Short Descriptor: Specimen collect COVID-19
  - Long Descriptor: specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
  - TOS: 5

- Code: G2024
  - Short Descriptor: Spec coll SNF/Lab COVID-19
  - Long Descriptor: specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source
**New Code Effective March 13, 2020**

Medicare covers medically necessary and reasonable clinical diagnostic laboratory tests when ordered by a physician or non-physician practitioner who is treating the patient. The following code will be added to the national HCPCS file with an effective date of March 13, 2020. This new code is contractor-priced until it is addressed at the annual Clinical Laboratory Public Meeting, which will take place in June or July 2020, as it was received after the 2019 public meeting.

- Code: 87635
  - Short Descriptor: SARS-COV-2 COVID-19 AMP PRB
  - Long Descriptor: Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique
  - TOS: 5

**New Codes Effective April 1, 2020**

Proprietary Laboratory Analysis (PLAs)

The listed new codes have been added to the national HCPCS file with an effective date of April 1, 2020, and do not need to be manually added to the HCPCS files by the MACs. However, these new codes are contractor-priced (where applicable) until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in June or July 2020, as they were received after the 2019 public meeting. MACs will only price PLA codes for laboratories within their jurisdiction.

- CPT Code 0163U
  - Long Descriptor: Oncology (colorectal) screening, biochemical enzyme-linked immunosorbent assay (ELISA) of 3 plasma or serum proteins (teratocarcinoma derived growth factor-1 [TDGF-1, Cripto-1], carcinoembryonic antigen [CEA], extracellular matrix protein [ECM]), with demographic data (age, gender, CRC-screening compliance) using a proprietary algorithm and reported as likelihood of CRC or advanced adenomas
  - Short Descriptor: ONC CLRCT SCR 3 PRTN ALG
  - Laboratory: BeScreened™-CRC, Beacon Biomedical Inc, Beacon Biomedical Inc
  - TOS: 5

- CPT Code 0164U
  - Long Descriptor: Gastroenterology (irritable bowel syndrome [IBS]), immunoassay for anti-CdtB and anti-vinculin antibodies, utilizing plasma, algorithm for elevated or not elevated qualitative results
  - Short Descriptor: GI IBS IA ANTI-CDTB&VINCULIN
  - Laboratory: ibs-smart™, Gemelli Biotech, Gemelli Biotech
  - TOS: 5

- CPT Code 0165U
  - Long Descriptor: Peanut allergen-specific IgE and quantitative assessment of 64 epitopes using enzyme-linked immunosorbent assay (ELISA), blood, individual epitope results and interpretation
  - Short Descriptor: PEANUT ALLG SPEC ASMT 64 EPI
  - Laboratory: VeriMAP Peanut Dx – Bead-based Epitope Assay, AllerGenis, AllerGenis
  - TOS: 5
• CPT Code 0166U
  ▪ Long Descriptor: Liver disease, 10 biochemical assays (α2-macroglobulin, haptoglobin, apolipoprotein A1, bilirubin, GGT, ALT, AST, triglycerides, cholesterol, fasting glucose) and biometric and demographic data, utilizing serum, algorithm reported as scores for fibrosis, necroinflammatory activity, and steatosis with a summary interpretation
  ▪ Short Descriptor: LIVER DS 10 BIOCHEM ASY SRM
  ▪ Laboratory: LiverFAST™, Fibronostics, Fibronostics
  ▪ TOS: 5

• CPT Code 0167U
  ▪ Long Descriptor: Gonadotropin, chorionic (hCG), immunoassay with direct optical observation, blood
  ▪ Short Descriptor: CHORNC GONADOTROPIN HCG IA
  ▪ Laboratory: ADEXUSDx hCG Test, NOWDiagnostics, NOWDiagnostics
  ▪ TOS: 5

• CPT Code 0168U
  ▪ Long Descriptor: Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma without fetal fraction cutoff, algorithm reported as a risk score for each trisomy
  ▪ Short Descriptor: FTL ANEUPLOIDY DNA SEQ ALYS
  ▪ Laboratory: Vanadis® NIPT, PerkinElmer, Inc, PerkinElmer Genomics
  ▪ TOS: 5

• CPT Code 0169U
  ▪ Long Descriptor: NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants
  ▪ Short Descriptor: NUDT15&TPMT GENE COM VRNT
  ▪ Laboratory: NT (NUDT15 and TPMT) genotyping panel, RPRD Diagnostics
  ▪ TOS: 5

• CPT Code 0170U
  ▪ Long Descriptor: Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis, and results reported as predictive probability of ASD diagnosis
  ▪ Short Descriptor: NEURO ASD RNA NEXT GEN SEQ
  ▪ Laboratory: Clarifi™, Quadrant Biosciences, Inc, Quadrant Biosciences, Inc
  ▪ TOS: 5

• CPT Code 0171U
  ▪ Long Descriptor: Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequence variants, rearrangements and minimal residual disease, reported as presence/absence
  ▪ Short Descriptor: TRGT GEN SEQ ALYS PNL DNA 23
  ▪ Laboratory: MyMRD® NGS Panel, Laboratory for Personalized Molecular Medicine, Laboratory for Personalized Molecular Medicine
  ▪ TOS: 5
Revised Codes Effective April 1, 2020

Proprietary Laboratory Analysis (PLAs)

The listed revised codes have been added to the national HCPCS file with an effective date of April 1, 2020, and do not need to be manually added to the HCPCS files by the MACs. However, these revised codes are contractor-priced (where applicable) until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in June or July 2020, as they were received after the 2019 public meeting. MACs shall only price PLA codes for laboratories within their jurisdiction.

- **CPT Code 0154U**
  - Long Descriptor: Oncology (urothelial cancer), RNA, analysis by real-time RT-PCR of the FGFR3 (fibroblast growth factor receptor 3) gene analysis (ie, p.R248C [c.742C>T], p.S249C [c.746C>G], p.G370C [c.1108G>T], p.Y373C [c.1118A>G], FGFR3-TACC3v1, and FGFR3-TACC3v3) utilizing formalin-fixed paraffin-embedded urothelial cancer tumor tissue, reported as FGFR gene alteration status
  - Short Descriptor: ONC URTHL CA RNA FGFR3 GENE
  - Laboratory: therascreen® FGFR RGQ RT-PCR Kit, QIAGEN, QIAGEN GmbH
  - TOS: 5

- **CPT Code 0155U**
  - Short Descriptor: ONC BRST CA DNA PIK3CA GENE
  - Laboratory: therascreen® PIK3CA RGQ PCR Kit, QIAGEN, QIAGEN GmbH
  - TOS: 5

Deleted Codes Effective April 1, 2020

Existing code 0006U is being deleted.

ADDITIONAL INFORMATION


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).

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 6, 2020</td>
<td>We revised this article to reflect revisions to CR11681. The CR revisions added code 87635 to the HCPCS file, effective March 13, 2020, and added two new COVID-19 test codes (G2023 and G2024), effective March 1, 2020, and removed the section on the delay of the CLFS reporting period. This revised article reflects these revisions. Also, in the article, we revised the CR release date, transmittal number and the web address of the CR. All other information remains the same.</td>
</tr>
<tr>
<td>March 13, 2020</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
**MM11694 Revised: April 2020 Update of the Ambulatory Surgical Center (ASC) Payment System**

**Table 1. New HCPCS Codes and Dosage Descriptors for Certain Drugs and Biologicals Effective April 1, 2020**

<table>
<thead>
<tr>
<th>CY 2020 HCPSC Code</th>
<th>CY 2020 Short Descriptor</th>
<th>CY 2020 Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9053</td>
<td>Inj. crizanlizumab-Lmca</td>
<td>Injection, crizanlizumab-Lmca, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9056</td>
<td>Injection, givosiran</td>
<td>Injection, givosiran, 0.5 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9057</td>
<td>Inj. cetirizine hydrochloride</td>
<td>Injection, cetirizine hydrochloride, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9058</td>
<td>Inj. pegfilgrastim-bmez</td>
<td>Injection, pegfilgrastim-bmez, biosimilar, (Ziextenso) 0.5 mg</td>
<td>K2</td>
</tr>
</tbody>
</table>

**PROVIDER ACTION NEEDED**

CR 11694 describes changes to and billing instructions for various payment policies implemented in the April 2020 ASC payment system update. This notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure your billing staffs are aware of these updates.

**BACKGROUND**

CR 11694 contains Calendar Year (CY) 2020 payment rates for separately payable procedures/services, drugs and biologicals, including descriptors for newly created Current Procedural Terminology (CPT) and Level II HCPCS codes. A corrected January 2020 Ambulatory Surgical Center Fee Schedule (ASCFS) File, an April 2020 Ambulatory Surgical Center Payment Indicator (ASC PI) File, and an April 2020 Ambulatory Surgical Center Drug File will be issued. No April 2020 ASCFS and no ASC Code Pair file will be issued due to CR 11694. The changes are as follows:

6. **Drugs, Biologicals, and Radiopharmaceuticals**
   a. **New HCPCS Codes and Dosage Descriptors for Certain Drugs and Biologicals Effective April 1, 2020**

   Several new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These new codes are effective April 1, 2020, and are listed in Table 1.
costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates, effective April 1, 2020, are available in the April 2020 update of ASC Addendum BB on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

c. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals with payment rates based on the ASP methodology may have their payment rates corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be accessible on the CMS website on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html.

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request their MAC to adjust previously processed claims.

7. January 2020 ASC Corrections

a. Radiopharmaceutical Payment Extension for Vizamyl and Neuraceq and Associated Procedure Payment (APP) Rate Changes

The Further Consolidated Appropriations Act of 2020 provides that, for a drug or biological furnished in the context of a clinical study on diagnostic imaging tests approved under a coverage with evidence development determination whose period of pass-through status under this paragraph concluded on December 31, 2018, and for which payment under this subsection was packaged into a payment for a covered Outpatient Department (OPD) service (or group of services) furnished beginning January 1, 2019, such pass-through status shall be extended for a 9-month period beginning on January 1, 2020, through September 30, 2020.

There are two diagnostic radiopharmaceuticals covered by this provision:

- Q9982 - Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries (Trade Name: Vizamyl)
- Q9983 - Florbetaben F18, diagnostic, per study dose, up to 8.1 millicuries (Trade Name: Neuraceq).

These two diagnostic radiopharmaceuticals will have OPPS pass-through status reinstated effective January 1, 2020.

ASCs that administered these radiopharmaceuticals associated with the clinical trial, with dates of service beginning January 1, 2020, may submit claims as appropriate. However, CMS expects limited, if any, claims for these radiopharmaceuticals by ASCs as the clinical study is not surgical in nature, and all entities are required to be approved to participate in this clinical study.

As stated above, the two diagnostic radiopharmaceuticals had previously been packaged. They were packaged into APC 5594 in the OPPS payment system. These radiopharmaceutical codes were also previously packaged in the ASC payment system. Effective January 1, 2020, these codes have been unpackaged from the 11 procedure codes in OPPS APC 5594. As a result of unpackaging, the payment rates for the corresponding 11 ASC procedure codes in Table 2 has changed slightly. The new procedure payment rates are included in the April 2020 quarterly update addenda, which is accessible on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.
The two diagnostic radiopharmaceutical HCPCS, their descriptors, and the ASCPI are included in Table 3.

### Table 3. Radiopharmaceutical Payment Extension for Vizamyl and Neuraceq

<table>
<thead>
<tr>
<th>CY 2020 HCPCS Code</th>
<th>CY 2020 Short Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9982</td>
<td>Flumetamol f18 diagnostic</td>
<td>K2</td>
</tr>
<tr>
<td>Q9983</td>
<td>Florbetaben f18 diagnostic</td>
<td>K2</td>
</tr>
</tbody>
</table>

Suppliers who think they may have received an incorrect payment for the procedures impacted by these corrections may request MAC adjustment of the previously processed claims.

b. **ASCPI Correction for Q5114 and Q5115.**

Q5114 and Q5115 entered the market after the publication of the OPPS/ASC final rule and were not included in the January 2020 update to the ASC system.

- Q5114 entered the market and was separately payable effective November 29, 2019.
- Q5115 entered the market and was separately payable effective November 11, 2019.

Therefore, the ASC PI is being corrected from Y5 to K2 for both of these codes effective on the date that each of these HCPCS entered the market. These two codes, short and long descriptors, ASCPIs, and effective dates are in table 4.

### Table 4. — ASCPI Correction for Q5114 and Q5115

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5114</td>
<td>Inj ogivri 10 mg</td>
<td>Injection, trastuzumab-dkst, biosimilar, (ogivri), 10 mg</td>
<td>K2</td>
<td>11/29/2019</td>
</tr>
<tr>
<td>Q5115</td>
<td>Inj truxima 10 mg</td>
<td>Injection, rituximab-abbs, biosimilar, (truxima), 10 mg</td>
<td>K2</td>
<td>11/11/2019</td>
</tr>
</tbody>
</table>

MACs will search claims history and reprocess claims, as appropriate, that include these codes within 45 days of the implementation date of CR 11694.

c. **Payment Correction for A9590.**

HCPCS A9590 was included in the January 2020 update to the ASC Payment System change request and the ASCPI file, with an ASCPI= K2. However, this HCPCS code was not included on the January 2020 ASC Drug file and was therefore contractor-priced. This code is being added to the ASC drug file, effective January 2020 with a payment rate.

Suppliers who think they may have received an incorrect payment may request contractor adjustment of the previously processed claims.
d. **Payment Correction for Certain Brachytherapy HCPCS Codes Retroactively, Effective January 1, 2020.**

A number of brachytherapy sources HCPCS code payment rates for January 2020 reflected an incorrect CY2020 payment amount in the January update ASCFS file. The payment rates have been corrected and are retroactive to January 1, 2020. The brachytherapy codes, short descriptor, and corrected payment rates are listed in Table 5.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Corrected CY2020 Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9527</td>
<td>Iodine i-125 sodium iodide</td>
<td>$31.27</td>
</tr>
<tr>
<td>C1716</td>
<td>Brachytx, non-str, gold-198</td>
<td>$116.46</td>
</tr>
<tr>
<td>C1717</td>
<td>Brachytx, non-str, hdr ir-192</td>
<td>$322.02</td>
</tr>
<tr>
<td>C1719</td>
<td>Brachytx, ns, non-hdriir-192</td>
<td>$62.97</td>
</tr>
<tr>
<td>C2616</td>
<td>Brachytx, non-str, yttrium-90</td>
<td>$17,091.57</td>
</tr>
<tr>
<td>C2634</td>
<td>Brachytx, non-str, ha, i-125</td>
<td>$181.91</td>
</tr>
<tr>
<td>C2635</td>
<td>Brachytx, non-str, ha, p-103</td>
<td>$56.38</td>
</tr>
<tr>
<td>C2638</td>
<td>Brachytx, stranded, i-125</td>
<td>$34.55</td>
</tr>
<tr>
<td>C2639</td>
<td>Brachytx, non-stranded, i-125</td>
<td>$35.64</td>
</tr>
<tr>
<td>C2640</td>
<td>Brachytx, stranded, p-103</td>
<td>$83.60</td>
</tr>
<tr>
<td>C2642</td>
<td>Brachytx, stranded, c-131</td>
<td>$76.71</td>
</tr>
<tr>
<td>C2643</td>
<td>Brachytx, non-stranded, c-131</td>
<td>$95.72</td>
</tr>
<tr>
<td>C2698</td>
<td>Brachytx, stranded, nos</td>
<td>$34.55</td>
</tr>
<tr>
<td>C2699</td>
<td>Brachytx, non-stranded, nos</td>
<td>$35.64</td>
</tr>
</tbody>
</table>

Suppliers who think they may have received an incorrect payment for the codes impacted by these corrections may request MAC adjustment of the previously processed claims.

8. **Correction for HCPCS Q4206**

HCPCS Q4206 (Fluid flow or fluid GF, 1 cc) is a packaged service (ASCPI=N1) and is currently recognized in the ASC payment system ASCPI file effective January 1, 2020. However, this code became effective October 1, 2019, in the ASC payment system as a packaged code. In the July 2020 CR, CMS intends to correct this oversight and add Q4206 to the ASCPI file retroactively effective October 1, 2019. ASCs are reminded not to bill packaged codes.

9. **Coverage Determinations**

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

**ADDITIONAL INFORMATION**


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).
KENTUCKY & OHIO

MM11747: New Waived Tests

MLN Matters Number: MM11747
Related CR Transmittal Number: R10048CP
Effective Date: July 1, 2020
Related CR Release Date: April 17, 2020
Related Change Request (CR) Number: 11747
Implementation Date: July 6, 2020

PROVIDER TYPE AFFECTED
This MLN Matters Article is for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
CR 11747 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so that they can accurately process claims. Make sure your billing staffs are aware of these newly added waived complexity tests.

BACKGROUND
The Current Procedural Terminology (CPT) codes for these new tests must have the modifier QW to be recognized as a waived test.

Note: The tests mentioned on the first page of the list attached to CR 11747 (CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- 80305QW, July 2, 2019, Express Diagnostics International, Inc., DrugCheck NxStep Onsite EDDP Drug Test Cup
- 80305QW, July 2, 2019, Express Diagnostics International, Inc., DrugCheck NxStep Onsite MDMA Drug Test Cup
- 80305QW, July 2, 2019, Express Diagnostics International, Inc., DrugCheck NxStep Onsite Morphine Drug Test Cup
- 80305QW, July 2, 2019, Express Diagnostics International, Inc., DrugCheck NxStep Onsite Nortriptyline Drug Test Cup
- 80305QW, July 2, 2019, Express Diagnostics International, Inc., DrugCheck Dip Drug Test
- 80305QW, July 2, 2019, Express Diagnostics International, Inc., DrugCheck Buprenorphine Dip Drug Test
- 80305QW, July 2, 2019, Express Diagnostics International, Inc., DrugCheck Butalbital Dip Drug Test
- 80305QW, July 2, 2019, Express Diagnostics International, Inc., DrugCheck EDDP Dip Drug Test
- 80305QW, July 2, 2019, Express Diagnostics International, Inc., DrugCheck Morphine Dip Drug Test

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**KENTUCKY & OHIO PART B**

**MEDICARE BULLETIN GR 2020-06 JUNE 2020**

- 80305QW, July 2, 2019, Express Diagnostics International, Inc., DrugCheck Nortriptyline Dip Drug Test
- 80305QW, July 2, 2019, Zero Chaos, zerochaos Drug Test Cup
- 80305QW, July 2, 2019, Zero Chaos, zerochaos Buprenorphine Drug Test Cup
- 80305QW, July 2, 2019, Zero Chaos, zerochaos Butalbital Drug Test Cup
- 80305QW, July 2, 2019, Zero Chaos, zerochaos EDDP Drug Test Cup
- 80305QW, July 2, 2019, Zero Chaos, zerochaos MDMA Drug Test Cup
- 80305QW, July 2, 2019, Zero Chaos, zerochaos Morphine Drug Test Cup
- 80305QW, July 17, 2019, Medical Disposables, MD Drug Screen MD Quick Cup Tests (MOR300)
- 80305QW, July 17, 2019, Medical Disposables, MD Drug Screen MD Quick Cup Tests (MOR2000)
- 80305QW, August 19, 2019, Micro Distributing II, LTD. STAT Cup One Step Drug Test
- 87807QW, August 28, 2019, Abbott Diagnostics Scarborough Inc., BinaxNow RSV Card (For NP Swabs and NP Wash Specimens)
- 82044QW, 82570QW, August 30, 2019, Jant Pharmacal Accutest M2 Microalbumin Urine Reagent Strips
- 80305QW, September 17, 2019, Easy Healthcare Corporations, Areta Multi-Drug Test Cup (MOR 300)
- 80305QW, September 17, 2019, Easy Healthcare Corporations, Areta Multi-Drug Test Cup (MOR 2000)
- 80305QW, September 26, 2019, Healgen Scientific, Helagen Accurate Multi Drug Urine Test Cup
- 87502QW, September 30, 2019, Cepheid GeneXpert Xpress System (Xpert Xpress Flu Assay) (GeneXpert Xpress IV hub configuration)
- 87631QW, September 30, 2019, Cepheid GeneXpert Xpress System (Xpert Xpress Flu/RSV Assay) (GeneXpert Xpress IV hub configuration)
- 80305QW, October 1, 2019, Tanner Scientific Inc., BluRapids Multi-Drug Urine Test Cup
- 87651QW, October 18, 2019, Cepheid GeneXpert Xpress System (Xpert Xpress Strep A) (GeneXpert Xpress IV hub configuration)
- 82010QW, October 24, 2019, AmVenturex, Inc., KetoCoach Blood Ketone Monitoring System
- 80305QW, November 26, 2019, Premier Biotech, Inc., Salvia Alcohol Test
- 80305QW, December 16, 2019, Confirm Bioscience, DrugConfirm Multi-Drug Urine Test Cup
- 80305QW, December 16, 2019, Confirm Bioscience, DrugConfirm Multi-Drug Urine Test DipCard
- 80305QW, December 19, 2019, Confirm Bioscience, DrugConfirm Multi-Drug Urine Test Cup II
- 80305QW, December 19, 2019, Confirm Bioscience, DrugConfirm Multi-Drug Urine Test Dip Card II
- 80305QW, January 6, 2020, Origin Diagnostics Origin Instant Drug Test
- 80305QW, January 6, 2020, Origin Diagnostics Origin Instant Drug Test (Buprenorphine)
- 80305QW, January 6, 2020, Origin Diagnostics Origin Instant Drug Test (Butalbital)
The October 2018 transmittal, CR 10819, mentioned the attachment accompanying the transmittal was re-organized to include a generic test system name and a statement to refer to the FDA waived analyte Internet site for those HCPCS codes with more than 10 test systems listed. For 87807QW, more than 10 test systems have been mentioned and only a generic test system will be listed in the attachment. You can find the associated MLN Matters Article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10819.pdf

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Note: MACs will not search their files to either retract payment or retroactively pay claims; however, MACs should adjust claims if you bring those claims to their attention.

ADDITIONAL INFORMATION
The official instruction, CR 11747, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10048CP.pdf.

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

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<td>April 17, 2020</td>
<td>Initial article released.</td>
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KENTUCKY & OHIO

MM11765: Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Code U0002 and 87635

MLN Matters Number: MM11765
Related CR Transmittal Number: R10066OTN
Effective Date: March 20, 2020

Related CR Release Date: April 24, 2020
Related Change Request (CR) Number: 11765
Implementation Date: May 8, 2020

PROVIDER TYPE AFFECTED
This MLN Matters Article is for facilities having a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver who bill Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
This article informs you about the addition of the QW modifier to HCPCS code U0002 (2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC) and 87635 [Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique]. Medicare will permit the use of codes U0002QW and 87635QW for claims submitted by facilities with a valid, current CLIA certificate.
BACKGROUND

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

The codes U0002 and 87635 were also included in CR 11681. See the related MLN Matters article, MM11681, at https://www.cms.gov/files/document/mm11681.pdf.

Currently there is no Food and Drug Administration (FDA)-approved or cleared test to diagnose or detect COVID-19. The FDA has issued several Emergency Use Authorizations (EUAs) for the use of new diagnostic test to detect the SARS-CoV-2 virus. During public health emergencies declared under Section 564 of the Federal Food Drug & Cosmetic Act (FD&C Act), the FDA is able to issue EUAs when certain criteria are met that allows for the use and distribution of potentially life-saving medical products to diagnose, treat, or prevent the disease, which can include diagnostic tests.

FDA does not categorize tests authorized under an EUA. Instead, the settings in which an EUA-authorized test may be used are described in the Letter of Authorization and, as discussed in the Guidance for Industry and Other Stakeholders: Emergency Use Authorization of Medical Products and Related Authorities, the FDA may determine that a test shall be deemed to be in a particular category. The terms “patient care settings outside of the clinical laboratory environment,” “near patient testing,” and “point of care” are mentioned in some EUAs, Policy for Diagnostic Tests for Coronavirus Disease-2019, and generally refer to settings that are equipped with the instrumentation and appropriately trained personnel necessary to perform the test, and may include settings such as hospitals, physician offices, urgent care, outreach clinics, and temporary patient care settings. In cases where these terms are used in EUAs, FDA has deemed such test to be appropriate for use in a CLIA waived setting for the time period of the emergency. These terms generally do not apply to home specimen collection or at home testing unless otherwise specified.

Those tests listed on the FDA’s EUAs for COVID-19 website, https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations, under the Test Kit Manufacturers and Commercial Laboratories Table that include the terms “patient care settings outside of the clinical laboratory environment,” “near patient testing,” or “point of care” in the EUA can be used by facilities having a current CLIA certificate of waiver. On March 20, 2020, FDA issued the first EUA containing the previous terms. HCPCS code U0002 and 87635 must have the modifier QW to be recognized as a test that can be performed in a facility having a CLIA certificate of waiver.

Note that MACs will not search their files to adjust claims already processed prior to implementation of CR 11765. They will adjust such claims that you bring to your MAC’s attention.

ADDITIONAL INFORMATION

The official instruction, CR 11765, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10066OTN.pdf.

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

DOCUMENT HISTORY

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<td>April 27, 2020</td>
<td>Initial article released.</td>
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SE20012: Supplier Education on Use of Upgrades for Multi-Function Ventilators

MLN Matters Number: SE20012  
Related CR Transmittal Number: N/A  
Effective Date: N/A  
Article Release Date: April 3, 2020  
Related Change Request (CR) Number: N/A  
Implementation Date: N/A

PROVIDER TYPE AFFECTED

This MLN Matters Article is for suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for ventilators, including multi-function ventilators, provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

Medicare’s multi-function ventilator policy applies to beneficiaries who are prescribed and meet the medical necessity coverage criteria for a ventilator and at least one of the four additional functions (namely, oxygen concentrator, cough stimulator, suction pump, and nebulizer). HCPCS code E0467 is used to describe multi-function ventilators.

This article informs DME suppliers that effective immediately, you may provide and bill for multi-function ventilators described by code E0467 as an upgrade in situations where beneficiaries only meet the coverage criteria for a ventilator.

BACKGROUND


An upgrade is an item that goes beyond what is medically necessary under Medicare’s requirements. When suppliers know that an item will not be paid in full because it does not meet the coverage criteria stated in the Local Coverage Determination (LCD), the supplier can still obtain partial payment at the time of initial determination if the claim is billed using one of the upgrade modifiers, GK or GL. The descriptions of the modifiers are:

- GK - Reasonable and necessary item/service associated with a GA or GZ modifier
- GL - Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN

If a supplier wants to collect from the beneficiary for the upgraded item provided, you must obtain a properly completed Advance Beneficiary Notice (ABN). If you obtain an ABN, on one claim line you bill with a GA modifier the HCPCS code that describes the item that was provided, in this case E0467. On the next claim line, you bill with a GK modifier the HCPCS code, in this case E0465 or E0466 that describes the item that is covered based on the LCD. (Note: The codes must be billed in this specific order on the claim). In this situation, the claim line with the GA modifier will be denied as not medically necessary with a “Patient Responsibility” (PR) message and the claim line with the GK modifier will continue through the usual claims processing. The beneficiary liability will be the sum of (a) the difference between the submitted charge for the GA claim line and the submitted charge for the GK claim line and (b) the deductible and co-insurance that relate to the allowed charge for the GK claim line.

If a supplier wants to provide the upgraded item without any additional charge to the beneficiary or if a physician ordered the upgraded item and the supplier decides to provide it at no additional charge to the beneficiary, then no ABN is obtained. In these instances, the supplier bills with a GL modifier the HCPCS code (in this case E0465 or E0466) that describes the item that is covered based on the LCD. Also, the supplier does not bill the HCPCS code that describes the item that was provided.
If the request for the upgraded item is from the beneficiary and the supplier decides to provide it at no additional charge, no ABN is obtained. On one claim line the supplier bills with a GZ modifier the HCPCS code (in this case E0467) that describes the item that was provided. On the next claim line, the supplier bills with a GK modifier the HCPCS code (in this case E0465 or E0466) that describes the item that is covered based on the LCD. *(Note: The codes must be billed in this specific order on the claim).*

Chapter 30, Section 50.4.2 of the Medicare Claims Processing Manual requires you to obtain an ABN (where the ABN is needed) from a Fee-For-Service Medicare beneficiary or his/her representative before providing him/her with a Medicare covered item or service that may not be covered in this particular instance if you intend to collect from the beneficiary. Recipients of ABNs include beneficiaries who have Medicaid coverage in addition to Medicare (that is, dual-eligible).

The following table summarizes the billing requirements:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Upgrade not used</th>
<th>Supplier provides upgrade and expects no additional payment</th>
<th>Supplier provides upgrade and wants beneficiary payment</th>
<th>Beneficiary Requests Upgrade and Supplier expects no additional payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABN required</td>
<td>N/A</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Modifier + HCPCS Codes required</td>
<td>GL Modifier with HCPCS E0465 or E0466</td>
<td>Do not use the HCPCS for upgrade item</td>
<td>In the following order: GA Modifier with HCPCS E0467 Next Claim line GK Modifier with HCPCS E0465 or E0466</td>
<td>In the following order: GZ Modifier with HCPCS E0467 Next Claim line GK Modifier with HCPCS E0465 or E0466</td>
</tr>
</tbody>
</table>

Remember that you will likely have financial liability for items or services if you knew or should have known that Medicare would not pay and you fail to obtain an ABN when required. In these cases, you may not collect funds from the beneficiary and you must make prompt refunds if funds were previously collected.

When a supplier decides to furnish an upgraded DMEPOS item but to charge Medicare and the beneficiary for the non-upgraded item, the supplier must bill for the non-upgraded item rather than the item the supplier actually furnished. The claim must include only the charge and HCPCS code for the non-upgraded item. The HCPCS code for the non-upgraded item must be accompanied by the GL modifier.

**ADDITIONAL INFORMATION**

The online replicable copies of the OMB approved ABN (CMS-R-131) and instructions for completion are available at [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html).

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).

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<td>April 3, 2020</td>
<td>Initial article released.</td>
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</table>
SE20011 Revised: Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

MLN Matters Number: SE20011 Revised
Related CR Transmittal Number: N/A
Effective Date: N/A

Note: We revised this article on April 10, 2020, to:
• Link to all the blanket waivers related to COVID-19
• Provide place of service coding guidance for telehealth claims
• Link to theTelehealth Video for COVID-19
• Add information on the waiver of coinsurance and deductibles for certain testing and related services
• Add information on the expanded use of ambulance origin/destination modifiers
• Provide new specimen collection codes for clinical diagnostic laboratories billing
• Add guidance regarding delivering notices to beneficiaries.

All other information is the same.

PROVIDER TYPE AFFECTED
This MLN Matters® Special Edition Article is for providers and suppliers who bill Medicare Fee-For-Service (FFS).

PROVIDER INFORMATION AVAILABLE

The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

More Information:
• Coronavirus Waivers and Flexibilities web page
• Instructions to request an individual waiver if there is no blanket waiver

BACKGROUND
Section 1135 and Section 1812(f) Waivers
As a result of this PHE, apply the following to claims for which Medicare payment is based on a “formal waiver” including, but not limited to, Section 1135 or Section 1812(f) of the Act:

1. The “DR” (disaster related) condition code for institutional billing, i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450.
2. The “CR” (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional, i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.
Medicare FFS Questions & Answers (FAQs) available on the Waivers and Flexibilities web page (https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities.html) apply to items and services for Medicare beneficiaries in the current emergency. These FAQs are displayed in these files:

- FAQs that apply without any Section 1135 or other formal waiver (https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf).
- FAQs apply only with a Section 1135 waiver or, when applicable, a Section 1812(f) waiver (https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf).

Blanket Waivers Issued by CMS

Billing for Professional Telehealth Distant Site Services During the Public Health Emergency
CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

View a complete list (https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes) of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.

When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the PHE, bill with:

- Place of Service (POS) equal to what it would have been had the service been furnished in-person
- Modifier 95, indicating that the service rendered was actually performed via telehealth

As a reminder, CMS is not requiring the CR modifier on telehealth services. However, consistent with current rules for telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

CMS released a video providing answers to common questions about the Medicare telehealth services benefit.

[Video](https://www.youtube.com/watch?v=bd9NKtybzo&feature=youtu.be)

Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services
The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the PHE; that result in an order for
or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital evaluation and management services

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

Previously, CMS made available the CS modifier for the gulf oil spill in 2010; however, CMS recently repurposed the CS modifier for COVID-19 purposes. Now, for services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

**COVID-19: Expanded Use of Ambulance Origin/Destination Modifiers**

During the COVID-19 PHE, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished. On an interim basis, we are expanding the list of destinations that may include but are not limited to:

- Any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH), or Skilled Nursing Facility (SNF)
- Community mental health centers
- Federally Qualified Health Centers (FQHCs)
- Rural health clinics (RHCs)
- Physicians’ offices
- Urgent care facilities
- Ambulatory Surgery Centers (ASCs)
- Any location furnishing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when an ESRD facility is not available
- Beneficiary’s home

CMS expanded the descriptions for these origin and destination claim modifiers to account for the new covered locations:

- Modifier D - Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
- Modifier E - Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the beneficiary’s home
• Modifier H - Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
• Modifier N - Alternative care site for SNF
• Modifier P - Physician’s office
• Modifier R - Beneficiary’s home


New Specimen Collection Codes for Laboratories Billing for COVID-19 Testing

To identify and reimburse specimen collection for COVID-19 testing, CMS established two Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

• G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
• G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

These codes are billable by clinical diagnostic laboratories.

Beneficiary Notice Delivery Guidance in Light of COVID-19

If you are treating a patient with suspected or confirmed COVID-19, CMS encourages the provider community to be diligent and safe while issuing the following beneficiary notices to beneficiaries receiving institutional care:

• Important Message from Medicare (IM)_CMS-10065
• Detailed Notices of Discharge (DND)_CMS-10066
• Notice of Medicare Non-Coverage (NOMNC)_CMS-10123
• Detailed Explanation of Non-Coverage (DENC)_CMS-10124
• Medicare Outpatient Observation Notice (MOON)_CMS-10611
• Advance Beneficiary Notice of Non-Coverage (ABN)_CMS-R-131
• Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN)_CMS-10055
• Hospital Issued Notices of Non-Coverage (HINN)

In light of concerns related to COVID-19, current notice delivery instructions provide flexibilities for delivering notices to beneficiaries in isolation. These procedures include:

• Hard copies of notices may be dropped off with a beneficiary by any hospital worker able to enter a room safely. A contact phone number should be provided for a beneficiary to ask questions about the notice, if the individual delivering the notice is unable to do so. If a hard copy of the notice cannot be dropped off, notices to beneficiaries may also be delivered via email, if a beneficiary has access in the isolation room. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice, and when and to where the email was sent.
• Notice delivery may be made via telephone or secure email to beneficiary representatives who are offsite. The notices should be annotated with the circumstances of the delivery, including the person delivering the notice via telephone, and the time of the call, or when and to where the email was sent.

We encourage the provider community to review all of the specifics of notice delivery, as set forth in Chapter 30 of the Medicare Claims Processing Manual at https://www.cms.gov/media/137111.
ADDITIONAL INFORMATION


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


DOCUMENT HISTORY

<table>
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| April 10, 2020 | Note: We revised this article to:  
• Link to all the blanket waivers related to COVID-19  
• Provide place of service coding guidance for telehealth claims  
• Link to the Telehealth Video for COVID-19  
• Add information on the waiver of coinsurance and deductibles for certain testing and related services  
• Add information on the expanded use of ambulance origin/destination modifiers  
• Provide new specimen collection codes for clinical diagnostic laboratories billing  
• Add guidance regarding delivering notices to beneficiaries.  
All other information is the same. |
| March 20, 2020 | We revised the article to add a note in the Telehealth section to cover the use of modifiers on telehealth claims and to explain the DR condition code is not needed on telehealth claims under the waiver. All other information is the same. |
| March 19, 2020 | We corrected a typo in the article. One of the e-visit codes was incorrectly stated as 99431 and we corrected it to show 99421. |
| March 18, 2020 | We revised this article to include information about the Telehealth waiver. All other information remains the same. |
| March 16, 2020 | Initial article released. |