# ACT

## ASK THE CONTRACTOR TELECONFERENCE

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March 2021

# COVID-19 Catch Up for J15 Providers Ask-the-Contractor Teleconference (ACT)

**J15 Provider Outreach & Education (POE) Team**
March 4, 2021

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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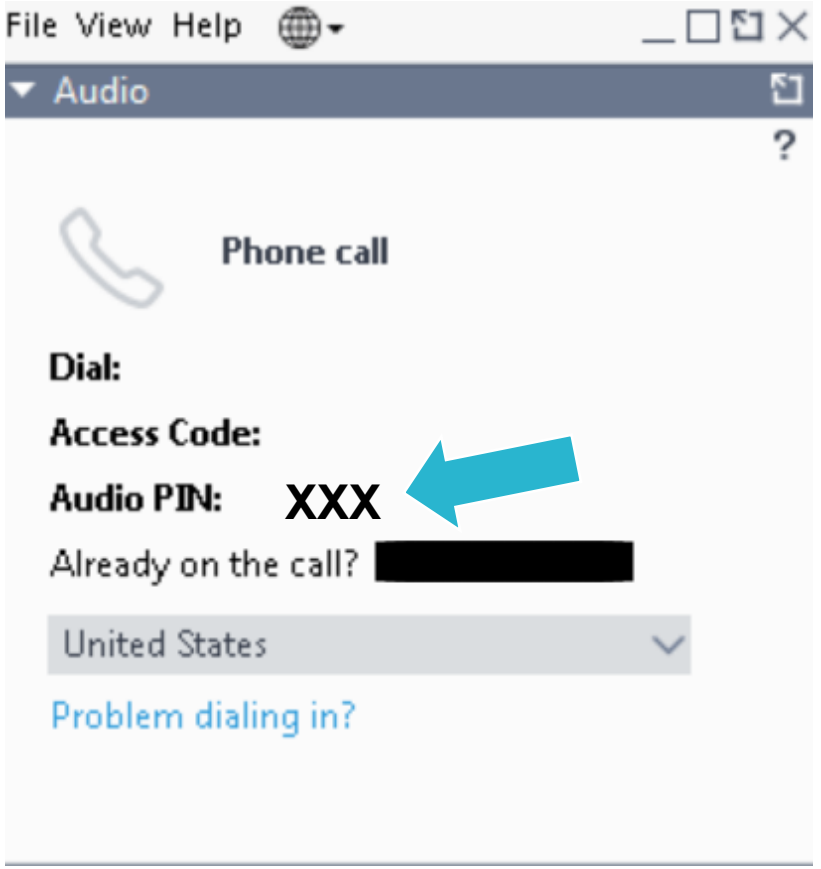

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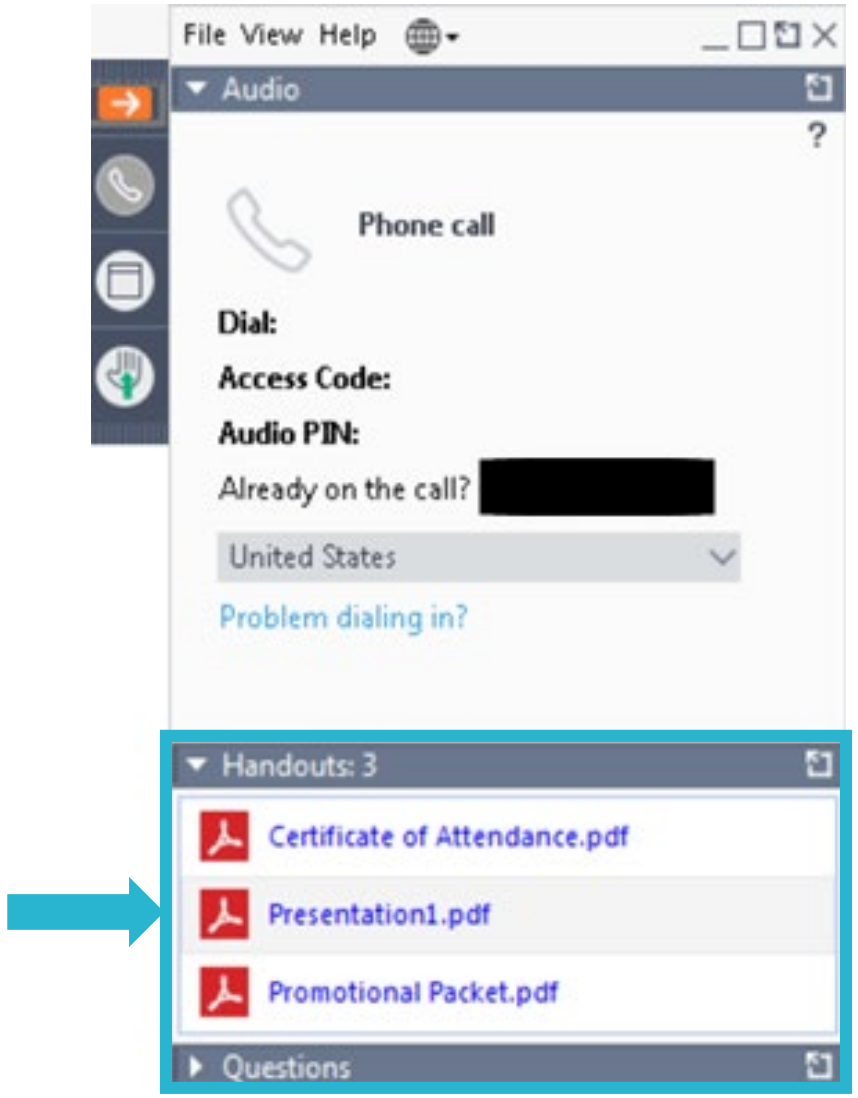

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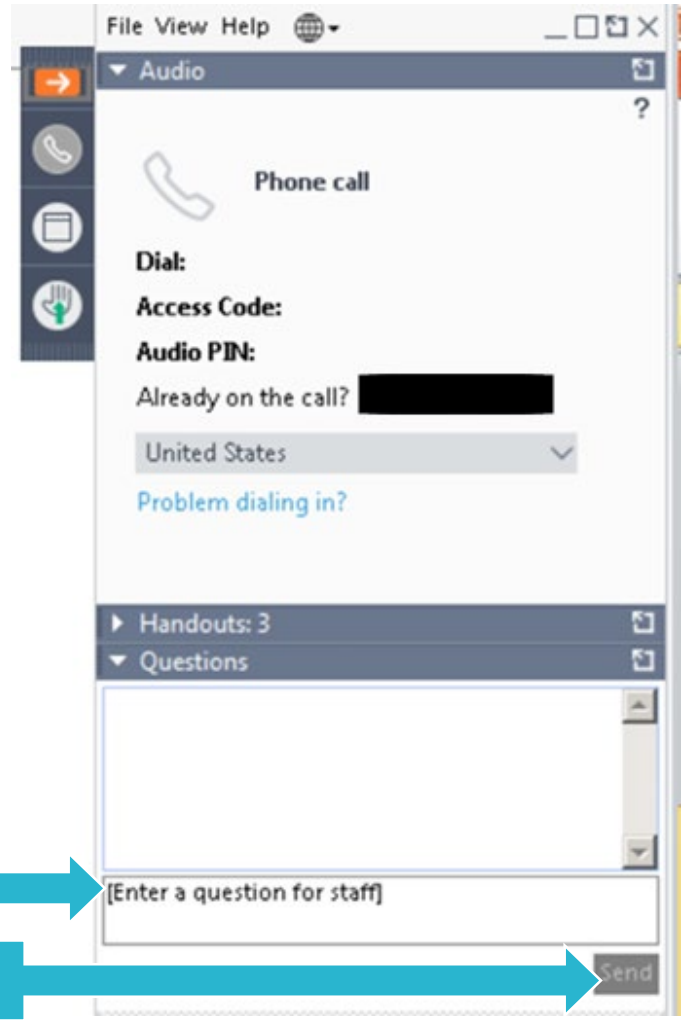


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# Topics of Discussion

- COVID-19 Vaccine
  - Brands/Types
  - Medicare Coverage
  - Who Can Administer
  - Related Billing
- Monoclonal Antibodies
- Telehealth/Modifier Reminders
- Audits
- Resources

March 2021

# COVID-19 VACCINE

UPDATE

# COVID19 Vaccine Coverage

- Covered under Medicare as a preventive vaccine at no cost to beneficiaries
- State Medicaid and CHIP programs will cover the vaccine without cost sharing
- The uninsured will receive the vaccine free of charge

# COVID-19 Vaccinations in the United States

Overall US COVID-19 Vaccine Deliveries and Administration:

COVID Data Tracker -

- https://covid.cdc.gov/covid-data-tracker/#datatracker-home
- https://covid.cdc.gov/covid-data-tracker/#vaccinations

❑ Maps, charts, and data provided by the CDC, updated daily by 8 pm ET

Represents all vaccine partners including:

- Jurisdictional partner clinics
- Retail pharmacies
- Long-term care facilities
- Federal Emergency Management Agency
- Health Resources
- Services Administration partner sites
- Federal entity facilities

# COVID-19 Vaccines Emergency Use Authorization (EUA)

- The FDA issued an EUA for COVID-19 vaccines

| Date | Vaccine | Details |
|---|---|---|
| Dec 11, 2020 | Pfizer-BioNTech (16 years of age and older) | • During the COVID-19 Public Health Emergency (PHE), Medicare will cover and pay for the administration of the vaccine (when furnished consistent with the EUA).<br>• When COVID-19 vaccine doses are provided by the government without charge, only bill for the vaccine administration.<br>  • Don't include the vaccine codes on the claim when the vaccines are free. |
| Dec 18, 2020 | Moderna (18 years of age and older) | |
| Feb 27, 2021 | Johnson & Johnson (Janssen) (18 years of age and older) | |

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# COVID-19 Vaccines (continued)

- You may bill for COVID-19 shot administration on a single claim, or submit claims on a roster bill for multiple patients at one time.
  - For roster, you must administer the same type of shot to 5 or more people on the same date.
  - Free PC-ACE billing software is also available for download
- Those interested in becoming a mass immunizer may enroll over the phone
- If you bill in three or more MAC jurisdictions, you may register as a centralized biller
  - Novitas is the MAC responsible for enrollment and claims processing
- If your patient participates in a Medicare Advantage Plan, submit your COVID-19 claims to traditional Medicare (CGS) for **all patients enrolled in Medicare Advantage in 2020 and 2021**.
- Check here for payment and HCPCS code structure.

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# COVID-19 Monoclonal Antibodies Emergency Use Authorization (EUA)

- The FDA issued an EUA for investigational monoclonal antibody therapies

| Date | Drug Name | Details |
|---|---|---|
| Nov. 10, 2020 | Bamlanivimab | • Used for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients who are at high risk for progressing to severe COVID-19 and/or hospitalization<br>• May only be administered in settings with immediate access to medications to treat a severe infusion reaction, such as anaphylaxis, and the ability to activate the Emergency Medical System (EMS), as necessary.<br>• Medicare will not pay for the COVID-19 monoclonal antibody products that providers receive for free.<br>  • Providers should only bill for the administration. |
| Nov. 21, 2020 | Casirivimab and Imdevimab (administered together) | |
| Feb. 9, 2021 | Bamlanivimab and Etesevima (administered together) | |

# COVID-19 Monoclonal Antibodies *(Cont.)*

- You may bill for COVID-19 monoclonal antibody infusion on a single claim, or submit claims on a roster bill for multiple patients at one time.
  - Be sure to document the EUA requirements for administration in the medical record.
  - Free PC-ACE billing software is also available for download
- Those interested in becoming a mass immunizer may enroll over the phone
- If you bill in three or more MAC jurisdictions, you may register as a centralized biller
  - Novitas is the MAC responsible for enrollment and claims processing

- Program instruction is available
- Check here for payment and HCPCS code structure.

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# Know the COVID-19 Vaccine Resources that are Available to You…

The COVID-19 Vaccines Factsheet is in plain language with information on COVID-19 vaccines. This fact sheet is available in multiple languages:

- Arabic | Spanish | Korean | Russian | Simplified Chinese | Tagalog | Traditional Chinese | Vietnamese

Vaccine Promotion Posters are available to encourage your community to get a COVID-19 vaccine. There are poster options for different audiences including long-term care facility workers, long-term care facility residents, and essential workers such as public safety workers, first responders, farmers and others. All of the vaccine promotion posters are also available in Spanish.

A COVID-19 Vaccinations Social Media Toolkit is available with sample Social Media messages and images for use on various social media channels that your organization uses, including Facebook, Twitter, and LinkedIn. You can use them as-is with the hashtag #SleeveUp or include your own identity.

A COVID-19 Vaccine Powerpoint Presentation is available for webinars, conferences and other events. The presentation is also available in Spanish.

Drop-in COVID-19 vaccine language may be used for e-newsletters, listserv announcements or other types of media.

Printable Stickers can be used for staff to handout to people who have received a COVID-19 vaccine. Some stickers are also available in Spanish. Widgets can be placed on your organization's website to enhance access to up to date information on COVID-19 vaccines.

# Who Can Administer the COVID-19 Vaccine

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# Already Enrolled in Medicare?

Medicare Providers

| Institutional | Non-Institutional |
| --- | --- |
| • Hospital<br>• Hospital Outpatient Department<br>• Skilled Nursing Facility (includes Parts A and B)*<br>• Critical Access Hospital<br>• End-Stage Renal Disease Facility<br>• Home Health Agency<br>• Hospice<br>• Comprehensive Outpatient Rehabilitation Facility<br>• Federally Qualified Health Center**<br>• Rural Health Clinic***<br>• Indian Health Services Facility | • Physician<br>• Non-Physician<br>• Clinic/Group Practice<br>• Pharmacy (enrolled as Part B)<br>• Mass Immunizer (roster bill only) |

# Enrolled in Medicare, but your provider type doesn't allow you to bill for administering vaccines?

Enrolling over the phone is easy and quick — call your MAC-specific enrollment hotline (PDF) and give your valid Legal Business Name (LBN), National Provider Identifier (NPI), Tax Identification Number (TIN), practice location and state license, if applicable.

| Institutional | Non-Institutional | Durable Medical Equipment (DME) |
|---|---|---|
| • Outpatient Physical Therapy<br>• Occupational Therapy<br>• Speech Pathology Services<br>• Histocompatibility Laboratory<br>• Religious Non-Medical Health Care Institution | • Independent Clinical Laboratory<br>• Ambulance Service Supplier<br>• Independent Diagnostic Testing Facility<br>• Intensive Cardiac Rehabilitation Supplier<br>• Mammography Center<br>• Medicare Diabetes Prevention Program Suppliers<br>• Portable X-ray Supplier<br>• Radiation Therapy Center<br>• Opioid Treatment Program<br>• Organ Procurement Organization<br>• Home Infusion Therapy Supplier | • Durable Medical Equipment Supplier<br>• Pharmacy (enrolled as DME supplier |

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# Centralized Billing Enrollment

Centralized billing allows mass immunizers to send all roster bill claims for flu, pneumococcal, and soon COVID-19 vaccinations to a single Medicare Administrative Contractor (MAC), Novitas, for payment, regardless of where you administer the shots. Medicare makes geographic payment adjustments based on the locality where you administer the shot. **You must submit all centralized biller claims as professional claims on a roster bill.**

Mass immunizers can enroll as centralized billers and send claims to Novitas, regardless of mass immunizer location, because Medicare pays based on where you deliver the service.

You must operate in at least 3 MAC jurisdictions and get prior approval from Novitas to centralize bill.

To become a centralized biller, call Novitas at 1-855-247-8428 with this information:

- Estimate of how many patients to whom you expect to administer the COVID-19 shot
- Approximate dates of shots
- List of states for COVID-19 vaccination clinics
- Type of services you generally deliver other than preventive vaccinations, if any (for example, ambulance, home health, visiting nurse)
- If you employ nurses who will administer the COVID-19 shot or if you hired them specifically to give these shots
- Names and addresses of all entities operating under provider application
- Contact information for the centralized billing program designated contact

https://www.cms.gov/files/document/covid-19-vaccine-enrollment-scenario-1.pdf

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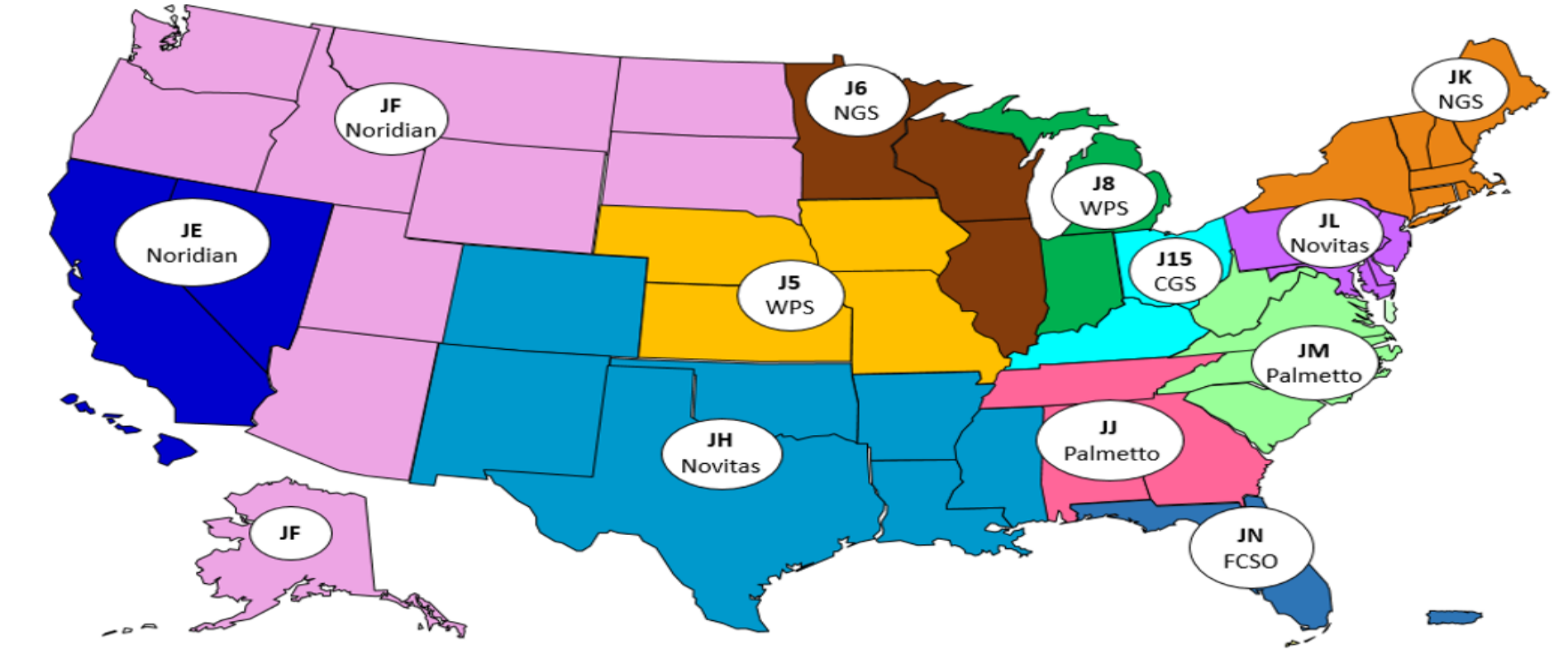
# How to submit a claim if you're a Medicare Advantage Plan contracted provider

If you are a Medicare Advantage contracted provider, submit claims for administering COVID-19 vaccines to Original Medicare through your MAC as outlined in the institutional and professional instructions slide ##



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# Helpful Definitions

**Mass Immunizers**: Mass immunizers can give flu, pneumococcal, and soon COVID-19 shots, to groups of individuals (like people who live in a retirement community). Mass immunizers can be a traditional provider, like a physician, or a non-traditional provider, like a drug store, public health clinic or senior center. We created the mass immunizer specialty for those providers who wouldn't otherwise be eligible for Medicare enrollment. Mass immunizers must submit all claims as roster billed professional claims.

**Roster billing**: This is a way for you to submit multiple claims for flu, pneumococcal, and soon COVID-19 shots. If you're enrolled as a mass immunizer, you must use roster billing.

- You must administer the same type of shot to 5 or more people on the same date of service. You must bill each type of shot on a separate roster bill. You can't combine flu, pneumococcal, and COVID-19 shot codes on the same roster bill.
- It's quick and easy to use roster billing for flu, pneumococcal, and soon COVID-19 shots.

**Centralized Billers**: Centralized billing allows mass immunizers to send all roster bill claims for flu, pneumococcal, and soon COVID-19 vaccinations to a single Medicare Administrative Contractor (MAC), Novitas, for payment, regardless of where you administer the shots. Medicare makes geographic payment adjustments based on the locality where you administer the shot. You must submit all centralized biller claims as professional claims on a roster bill.

**Order:** A communication from the treating physician/practitioner requesting a diagnostic test be performed for the patient.

# COVID-19 Vaccine and Monoclonal Antibody Infusion – Part A/HHH Billing Guidance

- Type of Bill:
  - Inpatient Part B:
    - Hospital – 12X
    - SNF – 22X
  - Outpatient:
    - Hospital – 13X
    - SNF – 23X
    - Home Health – 34X
    - End Stage Renal Disease – 72X
    - Comprehensive Outpatient Rehabilitation Facility – 75X
    - Hospice – 81X or 82X
    - Critical Access Hospital – 85X

# COVID-19 Vaccine and Monoclonal Antibody Infusion – Part A/HHH Billing Guidance

- Condition Codes:
  - A6 – 100% payment
  - 78 – New coverage not implemented by Medicare Advantage (if the beneficiary is enrolled in a MA plan)
    - Use the myCGS MBI Lookup Tool: https://cgsmedicare.com/parta/pubs/news/2018/05/cope7584.html
- Revenue Codes:
  - 0771 – Preventive care services, vaccine administration
  - 0636 – Pharmacy, drugs requiring detailed coding
    - Do **NOT** report revenue code 0636 or the product HCPCS code if it was received for free

# COVID-19 Vaccine and Monoclonal Antibody Infusion – Part A Billing Guidance

- HCPCS Codes:
  - CMS COVID-19 Vaccines and Monoclonal Antibodies
    - Do **NOT** report the product HCPCS code if it was received for free.
- Diagnosis Codes:
  - Z23 – Encounter for immunization
  - U071 – COVID-19 (monoclonal antibody infusion only)
- CGS COVID-19 Vaccine and Monoclonal Antibody Infusion – Part A / HH&H Billing Guidance
  - https://cgsmedicare.com/parta/pubs/news/2021/02/cope20503.html

# Resources for COVID-19 Vaccine

CGS - https://www.cgsmedicare.com/

- Select your line of business then select the COVID-19 located in the index section

COVID-19 - https://www.cms.gov/COVIDvax

- Vaccine Policies & Guidance

CMS COVID-19 https://www.cms.gov/covidvax-provider

- For providers

Medicare COVID-19 Vaccine Shot Administration Payment https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment

# Telehealth Reminders

# Home Health Face-to-Face Encounter (FTF)

As described in 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act, the FTF encounter can be performed via telehealth in accordance with the requirements under 1834(m)(4)(C) of the Social Security Act.

Under the expansion of telehealth under the 1135 waiver, beneficiaries are able to use telehealth technologies with their doctors and practitioners from home (or other originating site) for the FTF encounter to qualify for Medicare home health care.

Please see the FAQs regarding the 1135 telehealth waiver at: **https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf**

# What About Billing?

Only in-person visits are to be reported on the home health claim submitted to Medicare for payment.

On an interim basis, HHAs can report the costs of telecommunications technology on the HHA cost report as allowable administrative and general (A&G) costs by identifying the costs using a subscript between line 5.01 through line 5.19.

# Hospice FTF Encounter for Re-Certifications

Hospices are allowed to use 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and the clinician (e.g., FaceTime, Skype) to satisfy the FTF encounter requirement, which is required for the third benefit period and each subsequent 60-day benefit period thereafter.

An explanation of why the clinical findings from the hospice FTF encounter support that the patient still has a life expectancy of six months or less is required as part of the recertification narrative.

CMS does not believe telephone calls (audio only or TTY) would provide the necessary clinical information for a hospice physician to determine whether the patient continues to have a life expectancy of six months or less.

As such, telephone calls (audio only or TTY) cannot be used to satisfy the hospice FTF encounter requirement.

# What About Billing?

Only in-person visits - *with the exception of social work telephone calls* – may be reported on the hospice claim submitted to Medicare for payment.

For the purpose of service-intensity add-on (SIA) payments, only in-person visits performed by registered nurses and social workers provided during routine home care during the last seven days of life are eligible for these add-on payments.

Hospices may report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic as “other patient care services” on the cost report using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identify this cost center as “PHE for COVID-19”.

**https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf**

# Part B Telehealth & Modifier Reminders


# COVID-19 Telehealth Services

Access to Medicare telehealth services expanded so beneficiaries can receive services without having to travel to a healthcare facility.

Through the duration of the COVID-19 PHE:

- Medicare can pay for office, hospital, and other visits furnished via telehealth.
- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.
- Medical necessity and documentation requirements still apply to all services.
- CMS requires telecommunications technology with audio and video capabilities like Facetime and Skype.
  - Exceptions including those that may be furnished using audio-only technology are on the Telehealth Services list


# COVID-19 Telehealth Services *(Cont.)*

Tips to keep in mind:

- Do not use place of service (POS) code 02 (Telehealth) for services done under the waiver.
  - Instead, use the POS code that represents the place you would have billed had the service been performed face-to-face.
  - This will allow our systems to make appropriate payment, which would be the same amount as it would if the service was furnished in person.
- During the PHE, CPT modifier 95 should be applied to claim lines that describe services furnished via telehealth.

Check here for practitioners that can use telehealth and other flexibilities

COVID-19 FAQs are also available.

# COVID-19 Telehealth Services *(Cont.)*

For Calendar Year 2021, CMS is adding several services to the Telehealth list on a permanent basis. CMS is also adding additional services to the list on a temporary basis until the end of the calendar year in which the PHE ends:

- Telehealth Services listing

***NOTE**: Providers/suppliers must resume compliance with normal Medicare fee-for-service rules and regulations as soon as they are able to do so and, in any event, the waivers or modifications a provider/supplier was operating under are no longer available after the termination of the PHE.*

- *Refer to the Telehealth Services MLN Booklet for the original Telehealth guidelines*

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# COVID-19
# HCPCs Modifier CR

CMS revised MLN Matters Special Edition Article SE20011 on Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) to clarify when you must use modifier CR (catastrophe/disaster related) and/or condition code DR (disaster related) when submitting claims to Medicare.

This update includes a chart of blanket waivers and flexibilities that require the modifier or condition code.

https://www.cms.gov/files/document/se20011.pdf

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# COVID-19
# HCPCs Modifier CS

**COVID-19: Revised Clinician Codes Accepted with CS Modifier**

Effective March 18, 2020, the Families First Coronavirus Response Act requires Medicare Part B to cover beneficiary cost-sharing for provider visits when a COVID-19 diagnostic test is administered or ordered.

- CMS updated the list of codes (ZIP) that physicians and non-physician practitioners can use with the Cost-Sharing (CS) modifier.

For dates of service on or after January 1, 2021, through the end of the public health emergency, we'll accept these codes with the CS modifier:

- HCPCS codes G2250, G2251, and G2252
- CPT codes 98970, 98971, and 98972 (These replace HCPCS codes G2061 – G2063, which are accepted for services provided in 2020)
- CPT codes 98966, 98967, and 98968 are accepted for services with the CS modifier provided on or after March 18, 2020.

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# More on COVID-19!

| Topic | Resource |
|---|---|
| CGS COVID-19 Webpage | Links to all resources all on one page! |
| CMS COVID-19 Vaccine Resources | Check here for links to toolkits and coding instructions for the vaccines and antibodies. |
| Toolkit on COVID-19 Vaccine for MA Plans | Toolkit for Health insurers and Medicare Advantage plans. |
| Medicare Billing for COVID-19 Vaccine Shot Administration | Billing instructions for various types of claims |
| COVID-19 Diagnostic Laboratory Tests: Billing for Clinician Services | Assessment and collection billing instructions |
| Reminder: Payment for Diagnostic Laboratory Tests | Lab services MUST be submitted to CGS for payment. Medicare beneficiaries are not responsible. |

# COVID-19 New Repayment Terms for Medicare Loans Made to Providers During COVID-19

CMS advanced payments to providers to avoid a disruption in service for seniors

- CMS announced amended terms for payments issued under the Accelerated and Advance Payment (AAP) Program
  - Under the Continuing Appropriations Act, 2021 and Other Extensions Act, repayment will now begin one year from the issuance date of each provider or supplier's accelerated or advance payment.
    - Medicare will automatically recoup 25% of Medicare payments otherwise owed to the provider or supplier for 11 months.
    - At the end of the 11-month period, recoupment will increase to 50% for another 6 months.
    - If the provider or supplier is unable to repay the total amount of the AAP during this time-period (a total of 29 months), CMS will issue letters requiring repayment of any outstanding balance, subject to an interest rate of 4%.
    - The $175 billion issued in Provider Relief funds can be used towards repayment of these Medicare loans.
- Repayment Terms Fact Sheet
- Accelerated and Advance Payment FAQs

# Medicare Diabetes Prevention Program (MDPP)

The 2020 Centers for Disease Control (CDC) National Diabetes Statistics Report states:

- Total: 88 million people aged 18 years or older have prediabetes (34.5% of the adult US population)
- 65 years or older: 24.2 million people aged 65 years or older have prediabetes

The MDPP is designed to help Medicare beneficiaries who have symptoms of prediabetes develop healthy habits to prevent type 2 diabetes.

- Prediabetes is a serious health condition where blood sugar levels are higher than normal, but not high enough to be diagnosed as type 2 diabetes.

The MDPP model has been expanded as a new approach to address type 2 diabetes by treating patient with an indication of pre-diabetes

- Dietary changes
- Increased physical activity
- Weight control

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# Medicare Diabetes Prevention Program (MDPP)

The MDPP Resources

- MDPP billing and payment information
- Must enroll as an MDPP Supplier separate from your current enrollment

If interested in enrolling, please contact us at J15_PartB_Education@cgsadmin.com

***NOTE**: Before enrolling as an MDPP supplier, we suggest you obtain an NPI separate from your office NPI.*

# Patients Supplying Their Own Drugs

The Medicare Program provides limited benefits for outpatient drugs. The program covers drugs that are furnished under the “incident to” benefit (section 1861(s)(2)(A) or (B) of the Social Security Act), for an FDA approved drug or biological which is furnished by a physician’s practice or hospital (respectively), provided that the drug is not usually self-administered by the patient, and is reasonable and necessary for the diagnosis or treatment of the illness or injury according to accepted standards of medical practice. The physician practice or hospital **must** incur a cost for the drug or biological which is then administered by the physician or by auxiliary personnel employed by the practice or hospital and under the physician's personal supervision.

- Per the "incident to" guidelines explained above and in the Medicare Benefit Policy Manual, CMS Internet-Only Manual (IOM) Publication 100-02, Chapter 15, Sections 50 and 50.3 MBPM, providers are **not** allowed to instruct patients to purchase a drug themselves and bring it to the provider's office for administration. Claims that are billed with the chemotherapy administration codes 96401-96549 that do not have an associated drug in claim history, will deny. When the administration claim is processing, an allowed claim for the drug must be present, either on a prior claim or on the same claim as the administration.

For other regulations related to the billing of chemotherapy administration, refer to the IOM Medicare Claims Processing Manual Publication 100-04, Chapter 12, Section 30.5 at MCMP.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

# Audits

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# FY 2020 CERT Improper Payment Rate

CERT improper payment rate is 6.27% representing $25.74 billion in improper payments. (Compared to 7.25% and $28.91 billion in FY 2019)

| Claim Type | Improper Payment Rate | Improper Payment Amount |
|---|---|---|
| Part A Providers (excluding Hospital IPPS) | 6.15% | $10.92B |
| Part B Providers | 8.09% | $8.44B |
| Part A Providers (Inpatient Hospital) | 3.00% | $3.61B |
| DMEPOS | 31.80% | $2.77B |

CMS resumed CERT activities that were temporarily suspended in response to the PHE for the COVID-19 pandemic.

CERT began sending documentation request letters and conducting phone calls to request medical documentation for claims in the Reporting Years (RYs) 2021 and 2022.

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# Post Payment Reminder

MACs postponed all current Targeted Probe and Educate (TPE) reviews and associated edits and release the selected claims for payment

- The TPE program (intensive education to assess provider compliance through up to three rounds of review) will restart later.
- The MACs will continue to offer detailed review decisions and education as appropriate

CMS will issue additional technical direction after the Public Health Emergency (PHE) for resuming normal operations

August 2020

Beginning August 17th, the MACs resumed with postpayment reviews of items/services provided before March 1, 2020

- CGS may perform a post payment review of claims, meaning that medical documentation is requested for claims that have already been processed and paid
- More information available under Medical Review Tab on each LOB website

# Defining the Postpayment Review Process

We will initiate a provider-specific, postpayment review based upon:

- Data analysis – initiate targeted, provider specific
- Postpayment review upon referral
- Recovery Auditor Contractor (RAC)
- Comprehensive Error Rate Testing (CERT)
- Unified Program Integrity Contractor (UPIC)
- Office of Inspector General (OIG), or Government Accountability Office (GAO) when directed by CMS

Target providers/suppliers who have:

- Historically high claim denial rates
- Have billing practices that vary from their peers, or when evidence suggests that there is a potential risk to the Medicare Trust Fund

Reference as discussed in §3.2.1. at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R613PI.pdf

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**HHH**

https://www.cgsmedicare.com/hhh/medreview/activitylog.html



# Home Health and Hospice Medical Review Activity Log

## Hospice Postpayment

| Review Topic | Reason Code | Description | Review Type | Status |
|---|---|---|---|---|
| **LOS 730+ days** | 5M000 | This review selects any hospice claim with a length of stay (LOS) 730+ days excluding diagnosis codes between C00 and D49.9 submitted with dates of service prior to March 1, 2020. | Postpayment | Active |
| **GIP ≥ 7 days** | 5M001 | This review selects any hospice claim with revenue code 0656 greater than or equal to 7 days submitted with dates of service prior to March 1, 2020. | Postpayment | Active |

## Home Health Postpayment

| Review Topic | Reason Code | Description | Review Type | Status |
|---|---|---|---|---|
| **Home Health Medical Necessity** | 5L000 | This review selects any home health claim with 2 to 6 visits and a diagnosis code of I11.0, Z46.6, J44.1, I10, J44.9, G20, I25.10, N39.0, J18.9, or I87.2 submitted with dates of service prior to March 1, 2020. | Postpayment | Active |

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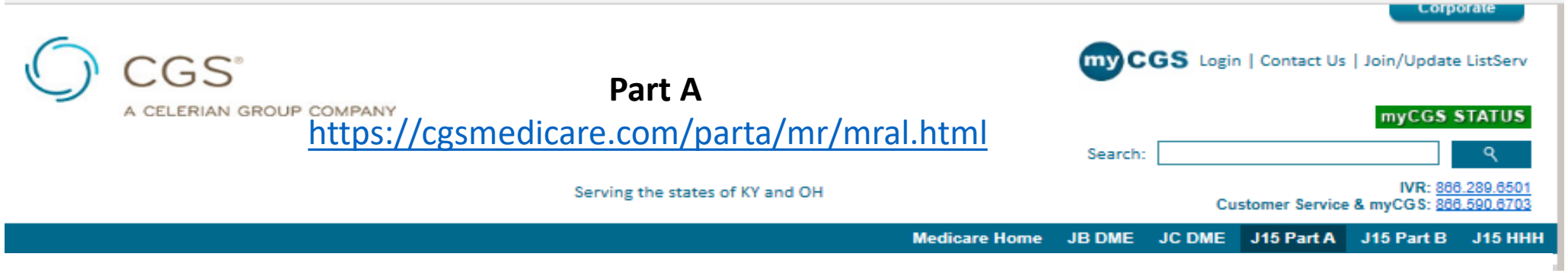
**Part A**

https://cgsmedicare.com/parta/mr/mral.html




# Part A Medical Review Activity Log

## Part A Prepayment

| Edit Code | Description | Review Type | Status | Documentation Requirements Checklist |
|---|---|---|---|---|
| 5TC3R | Review of services related to non-covered services/Category III CPT code utilization | Prepayment Review | Active | Non-covered Services/Category III CPT Code Utilization ADR Checklist |

## Part A Postpayment

| Edit Code | Description | Review Type | Status | Documentation Requirements Checklist |
|---|---|---|---|---|
| 51106 | Review of HCPCS code G0424 for services related to Pulmonary Rehabilitation, including exercise | Postpayment Review | Active | Pulmonary Rehabilitation ADR Checklist |
| 51105 | Review of HCPCS code 97110 for services related to Therapeutic Exercise | Postpayment Review | Active | Therapeutic Exercise ADR Checklist |
| 51104 | Review of HCPCS code J9299 for services related to Nivolumab, 1mg injection | Postpayment Review | Active | Nivolumab ADR Checklist |
| 51103 | Review of HCPCS code J9312 for services related to Rituximab, 10mg injection | Postpayment Review | Active | Rituximab ADR Checklist |
| 51102 | Review of HCPCS code J2505 for services related to Neulasta, Pegfilgrastim, 6mg injection | Postpayment Review | Active | Neulasta ADR Checklist |
| 51101 | Review of HCPCS code G0277 for services related to Hyperbaric Oxygen Therapy (HBOT) | Postpayment Review | Active | HBOT ADR Checklist |

ACT TELECONFERENCE

# Part B

https://www.cgsmedicare.com/partb/mr/activity_log.html



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## MR Activities

***Updated: 08.26.20***

| Review Topic | Codes Involved | Review Type | Status | Resources |
|---|---|---|---|---|
| Ambulance | A0428 w/A0425<br>A0429 W/A0425 | Post Pay Service Specific | Active | • Ambulance Fact Sheet PDF<br>• Ambulance Decision Tree<br>• Ambulance Documentation Checklist Tool PDF |
| Drugs/Biologicals | J0129, J0178, J2507 | Post Pay Service Specific | Active | • HCPCS J0129 PDF<br>• HCPCS J0178 PDF<br>• HCPCS J2507 PDF<br>• Drugs & Biologicals Decision Tree<br>• Drugs and Biological Services Documentation Checklist Tool PDF<br>• IOM 100-4, Processing Manual, Chapter 17 – Drugs and Biologicals PDF |
| Cataract Removal | 66821, 66982, 66984 | Post Pay Service Specific | Pending | |
| Annual Wellness Visit | G0438 & G0439 | Post Pay Service Specific | Pending | |
| CT – Abdomen | 74176, 74177 | Post Pay Service Specific | Pending | |
| CT – Chest | 71250, 71260 | Post Pay Service Specific | Pending | |
| Physical Therapy/Occupational Therapy | 97110, 97112, 97140, 97530 | Post Pay Service Specific | Pending | |
| Psychotherapy | 90832, 90834, 90837 | Post Pay Service Specific | Pending | |

**Part A main page** - https://www.cgsmedicare.com/parta/index.html

- **866.590.6703** Provider Contact Center (PCC) – Option 1: Customer Service

**HHH main page** - https://www.cgsmedicare.com/hhh/index.html

- **877.299.4500** PCC – Option 1: Customer Service

**Part B main page** - https://www.cgsmedicare.com/partb/index.html

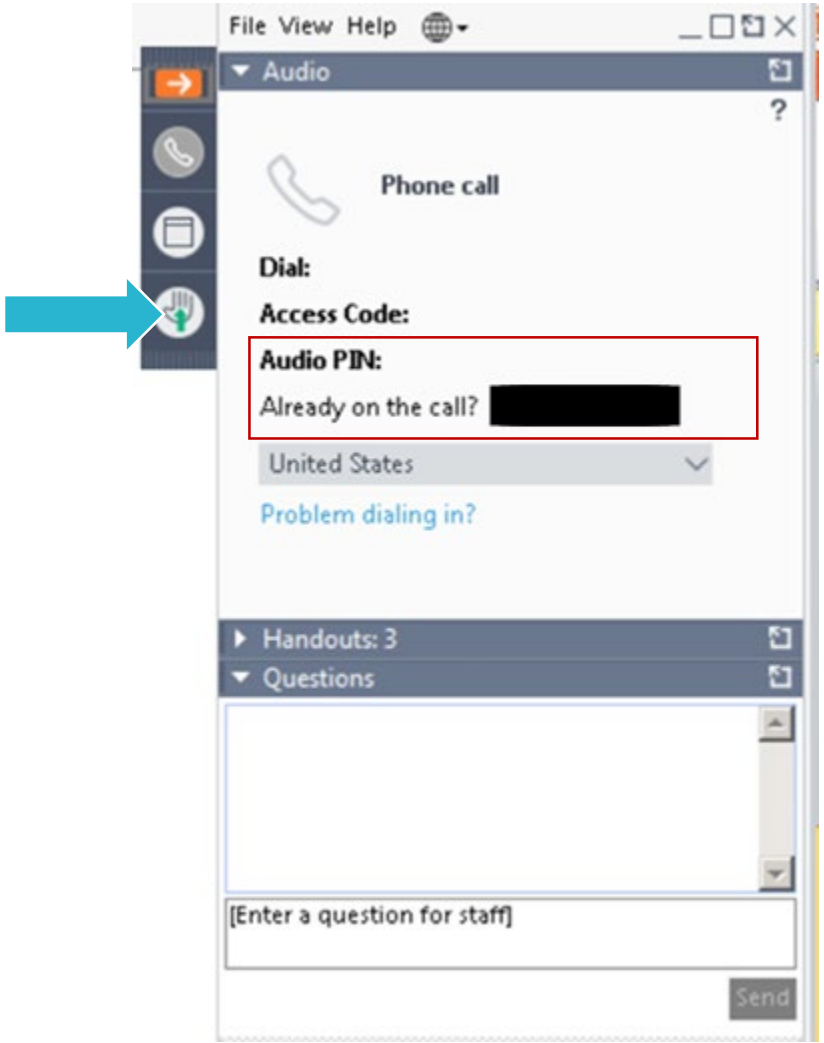
- **866.276.9558** PCC – Option 1: Customer Service

# CGS Contacts

# WEBINAR INSTRUCTIONS

## How to Participate Today

- To Ask a Verbal Question: **Raise Your Hand**
- The **Green Arrow** means your hand is not raised (Click to raise your hand)
- The **Red Arrow** means your hand is raised (Click to lower your hand)



# WEBINAR INSTRUCTIONS

## How to Participate Today

To ask a question by **Raising Your Hand** . . .

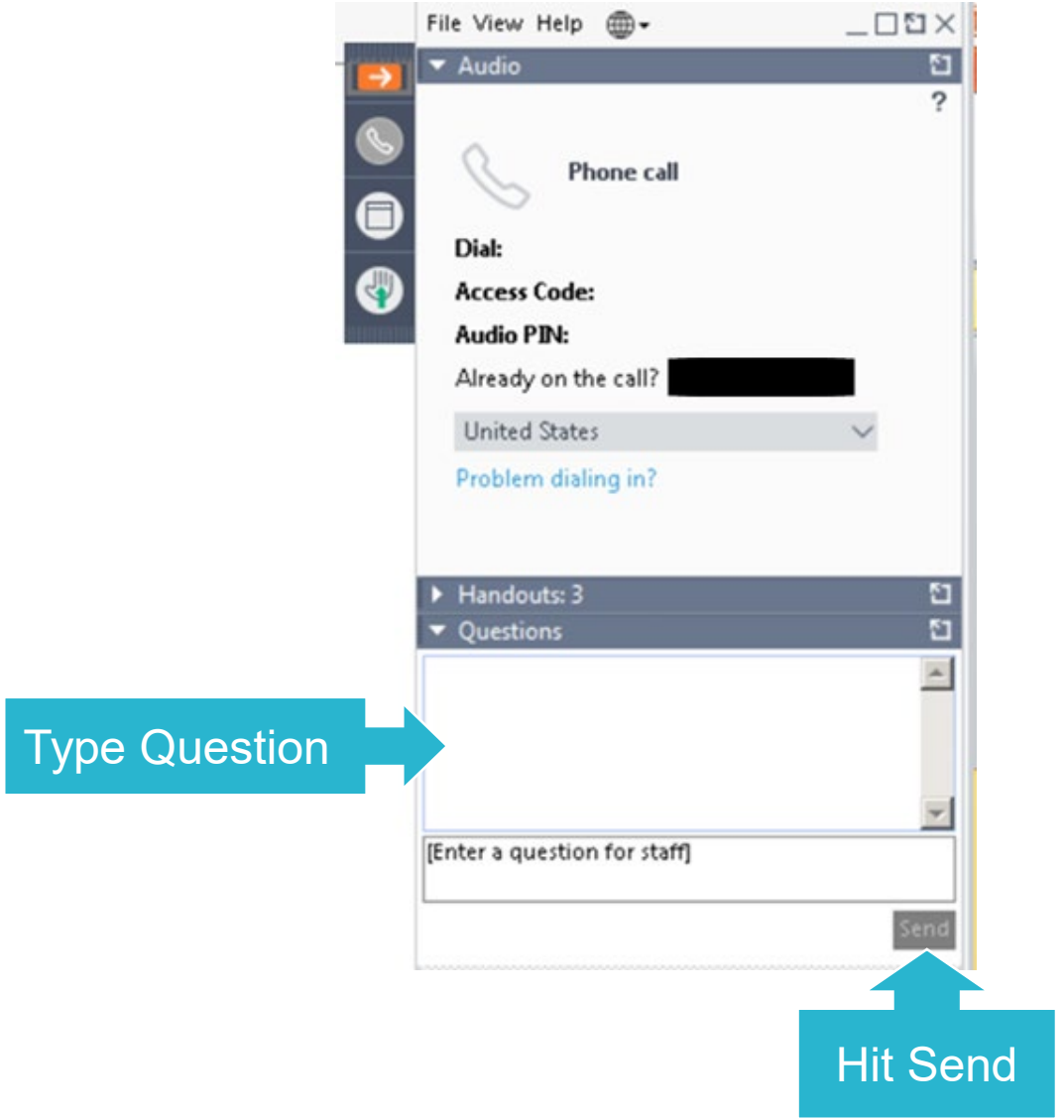
Hand Lowered
(Green Arrow)

Hand Raised
(Red Arrow)

# WEBINAR INSTRUCTIONS

## How to Participate Today

To ask a question by using the **Question Box**



# STAY CONNECTED

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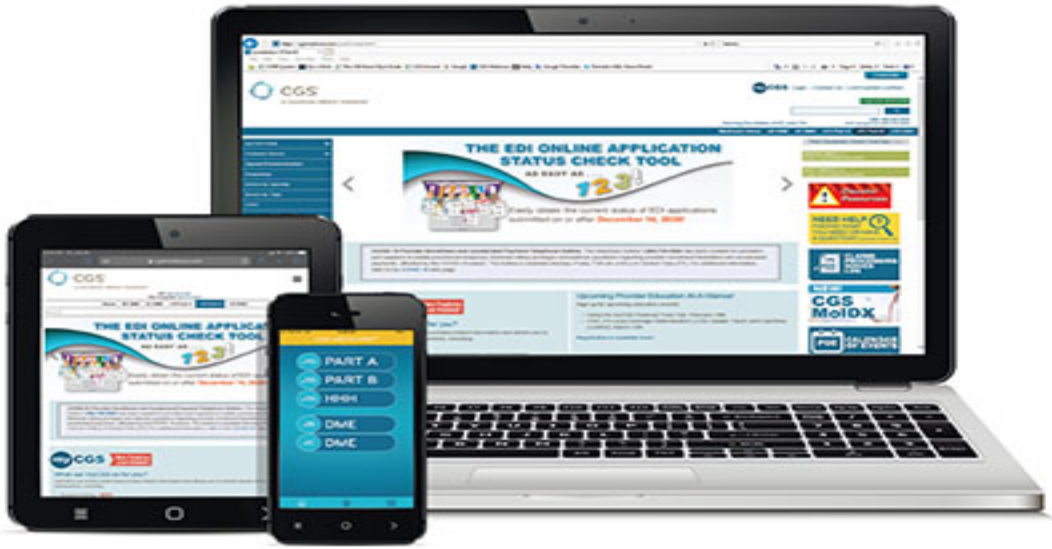


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