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Official CMS news from the Medicare Learning Network®

Thursday, July 30, 2020

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CMS Updates Data on COVID-19 Impacts on Medicare Beneficiaries

On July 28, CMS released its first monthly update of data that provides a snapshot of the impact of COVID-19 on the Medicare population. For the first time, the snapshot includes data for American Indian/Alaskan Native Medicare beneficiaries. The new data indicate that American Indian/Alaskan Native beneficiaries have the second highest rate of hospitalization for COVID-19 among racial/ethnic groups after Blacks. Previously, the number of hospitalizations of American Indian/Alaskan Native beneficiaries was too low to be reported.

The updated data confirm that the COVID-19 public health emergency is disproportionately affecting vulnerable populations, particularly racial and ethnic minorities. This is due, in part, to the higher rates of chronic health conditions in these populations and issues related to the social determinants of health.

In response to the first Medicare data snapshot and related call to action from CMS Administrator Seema Verma on June 22, the CMS Office of Minority Health hosted three listening sessions with stakeholders who serve and represent racial and ethnic minority Medicare beneficiaries. These sessions provided helpful insight into ways in which CMS can address social risks and other barriers to health care that will help in our efforts to reduce health disparities.

The updated data on COVID-19 cases and hospitalizations of Medicare beneficiaries covers the period from January 1 to June 20, 2020. It is based on Medicare claims and encounter data CMS received by July 17, 2020.

Other key data points:

- Black beneficiaries continue to be hospitalized at higher rates than other racial and ethnic groups, with 670 hospitalizations per 100,000 beneficiaries
- Beneficiaries eligible for both Medicare and Medicaid – who often suffer from multiple chronic conditions and have low incomes – were hospitalized at a rate more than 4.5 times higher than beneficiaries with Medicare only (719 versus 153 per 100,000)
- Beneficiaries with end-stage renal disease continue to be hospitalized at higher rates than other segments of the Medicare population, with 1,911 hospitalizations per 100,000 beneficiaries, compared with 241 per 100,000 for aged and 226 per 100,000 for disabled
- CMS paid $2.8 billion in Medicare fee-for-service claims for COVID-related hospitalizations, or an average of $25,255 per beneficiary

For More Information:

- Preliminary Medicare COVID-19 Data Snapshot
- FAQs

Short-Term Acute Care Hospitals: Submit Occupational Mix Surveys by September 3

CMS collects data every three years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. Hospitals must submit their occupational mix surveys along with complete supporting documentation to their Medicare Administrative Contractors (MACs) by no later than September 3, 2020. Hospitals may then submit revisions to their occupational mix surveys to their MACs, if needed, by no later than September 10, 2020.

CMS granted this extension for hospitals nationwide due to COVID-19.

PEPPERs for SNFs, Hospices, IRFs, IPFs, CAHs, and LTCHs

Fourth quarter FY 2019 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for Skilled Nursing Facilities (SNFs), hospices, Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs), Critical Access Hospitals (CAHs), and Long-Term Care Hospitals (LTCHs). These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities.

For More Information:

- Visit the Distribution Schedule webpage for guidance on accessing your report
- Visit the PEPPER Resources website to review user's guides, recorded training sessions, FAQs, and examples of how other providers are using the report
- Visit the Help Desk if you have questions or need help obtaining your report
- Send us your feedback or suggestions

Hospice Quality Reporting Program: HART v1.6.0

The Hospice Abstraction Reporting Tool (HART) v1.6.0 is available. Use this free, Java-based software application to collect and maintain facility, patient, and Hospice Item Set (HIS) record information for submission to national data repositories. HART is offered in two configuration types: Standalone and network client. Visit the HIS Technical webpage for more information.

Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Medicare pays Medicare Diabetes Prevention Program (MDPP) suppliers to furnish group-based intervention to at-risk eligible Medicare beneficiaries:

- Centers for Disease Control and Prevention (CDC)-approved National Diabetes Prevention Program curriculum
- Up to 2 years of sessions delivered to groups of eligible beneficiaries

Find out how to become a Medicare enrolled MDPP supplier:

- Obtain CDC preliminary or full recognition - Takes at least 12 months to obtain preliminary recognition and up to 24 additional months to achieve full recognition: See the Supplier Fact Sheet and CDC website
- Prepare for Medicare enrollment: See the Enrollment Fact Sheet and Checklist
- Apply to become a Medicare enrolled MDPP supplier (existing Medicare providers must re-enroll): See the Enrollment Webinar Recording and Enrollment Tutorial Video
- Furnish MDPP service: See the Session Journey Map
- Submit claims to Medicare: See the Billing and Claims Webinar Recording, Billing and Claims Fact Sheet, and Billing and Payment Quick Reference Guide

For More Information:

- MDPP Participants: CMS Flexibilities to Fight COVID-19
- MDPP Expanded Model Booklet
- Materials from Medicare Learning Network call on June 20, 2018
- MDPP webpage
- CDC - CMS Roles Fact Sheet
- Contact mdpp@cms.hhs.gov

Claims, Pricers & Codes

COVID-19: Laboratory Claims Requiring the NPI of the Ordering/Referring Professional — Update

During the COVID-19 Public Health Emergency (PHE), CMS relaxed requirements for a limited number of laboratory tests required for a COVID-19 diagnosis. These tests do not require a practitioner order during the PHE. We added a new test to this list: CPT 87426 (Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19]).

Any health care professional authorized under state law may order these tests. Medicare will pay for these tests without a written order from the treating physician or other practitioner:

- If an order is not written, you do not need to provide the National Provider Identifier (NPI) of the ordering or referring professional on the claim
- If an order is written, include the NPI of the ordering or referring professional, consistent with current billing guidelines

For More Information:

- Laboratory tests with modified requirements
- Interim final rule

Medicare Diabetes Prevention Program: Valid Claims

For a claim to be valid under the Medicare Diabetes Prevention Program (MDPP), you must have both:

- Centers for Disease Control and Prevention (CDC) preliminary or full recognition; see the Supplier Fact Sheet and CDC website for more information

- Separate Medicare enrollment as an MDPP supplier (Specialty D1); see the Enrollment Fact Sheet and Checklist

Important:
If you do not have a separate Medicare enrollment as an MDPP supplier and you submit a claim for MDPP services, your claim will be rejected.

Medicare enrolled MDPP suppliers: See the Quick Reference Guide to Payment and Billing and Billing and Claims Fact Sheet for information on valid claims:

- MDPP Medicare beneficiary eligibility data is returned via the HIPAA Eligibility Transaction System (HETS) on the 271 response; use this data to determine if a beneficiary meets the criteria to receive MDPP services
- Submit claims when a performance goal is met, and report codes only once per eligible beneficiary (except G9890 and G9891)
- List each HCPCS code with the corresponding session date of service and the coach's National Provider Identifier
- List all HCPCS codes associated with a performance payment (including non-payable codes) on the same claim
- Include Demo code 82 in block 19 (Loop 2300 segment REF01 (P4) and segment REF02 (82)) to identify MDPP services
- Do not include codes for other, non-MDPP services on the same claim

For More Information:

- MDPP Expanded Model Booklet
- MDPP webpage
- For trouble with MDPP billing and claims, contact your Medicare Administrative Contractor

Events

National CMS/CDC Nursing Home COVID-19 Training Series Webcast — July 30

COVID-19 Knowledge for the Frontline Staff
Thursday, July 30 from 4 to 5 pm ET

Register for this webcast.

Find out how to support the health and well-being of older adults, their care partners, nursing home team members, and other stakeholders during COVID-19. This series is brought to you by CMS, Centers for Disease Control and Prevention (CDC), and hosted by the Quality Improvement Organization Program, a national network of Quality Innovation Network-Quality Improvement Organizations serving every state and territory.

Miss a training? View recordings, slides, and resources on QIOProgram.org.

MLN Matters® Articles

Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Code 87426

CMS issued a new MLN Matters Article MM11927 on Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Code 87426. Learn about this QW modifier for Infectious agent antigen detection by immunoassay technique by clinical laboratories.

Overview of the Repetitive, Scheduled Non-Emergent Ambulance Prior Authorization Model — Revised

CMS revised MLN Matters Special Edition Article SE1514 on Overview of the Repetitive, Scheduled Non-emergent Ambulance Prior Authorization Model to provide information on transportation for beneficiaries.

Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan — Revised

CMS revised MLN Matters Article MM11580 on Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan. Learn about inpatient claims when an MA plan becomes effective during admission.

Publications

Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 4

CMS issued a new Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 4 Medicare Learning Network Educational Tool. Learn about:

- Skilled nursing facility outpatient services that are not separately payable
- Medical necessity and documentation requirements for urological supplies and hyperbaric oxygen therapy for diabetic wounds

Visit the newsletter archive for past editions.

Home Health, IRF, LTCH, and SNF Quality Reporting Programs: COVID-19 PHE

COVID-19 Public Health Emergency (PHE) tip sheets are available for the home health, Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Skilled Nursing Facility (SNF) Quality Reporting Programs. These tip sheets provide guidance on quality data submission requirements starting July 1, 2020, now that the temporary exemptions ended.

- Home Health tip sheet
- IRF tip sheet
- LTCH tip sheet
- SNF tip sheet

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