Key Revenue Integrity Takeaways from COVID-19 Interim Final Rule CMS-9912-IFC

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CMS-9912-IFC: Housekeeping Items

- The rule was published by CMS on October 28, 2020 and can be read in it's entirety at the following link:
  - https://www.cms.gov/files/document/covid-vax-ifc-4.pdf

- CMS is waiving the 30-day delay of implementation for the rule, meaning **all policy changes outlined in the IFC are effective beginning November 6, 2020** – the date the rule was formally published in the Federal Register

- This presentation will focus on policy changes outlined in CMS-9912-IFC that will impact revenue integrity processes

- Craneware's Insight Article: CWI1274, "CMS Interim Final Rule – Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (PHE)"

Coverage of COVID-19 Vaccines and Administration Services

Medicare Beneficiaries: COVID-19 Vaccine Coverage

- Medicare generally covers preventative vaccines and their associated administration charges with no cost-sharing responsibility for beneficiaries

- The CARES Act further codified that CMS must cover COVID-19 vaccines and their associated administration charges at no-cost to Medicare beneficiaries

- Typically, for a vaccine to be covered by Medicare the product must obtain full licensure from the FDA (known as a Biologics License Application)

- In the IFC, CMS states that it will cover any COVID-19 vaccine granted an Emergency Use Authorization by the FDA
  - "There are no historical examples in which Medicare has covered vaccines for which an EUA was issued by FDA"

Medicare Beneficiaries: COVID-19 Vaccine Billing and Reimbursement

- CMS will allow “mass immunizers” to provide COVID-19 vaccinations and for these providers to “roster bill” for these mass immunization services

- COVID-19 vaccines will be reimbursed under the normal payment methodology depending on where the vaccine is administered:
  - Physician Fee Schedule Claims – 95% of Average Wholesale Price (AWP)
  - Outpatient Prospective Payment Claims – Reasonable Cost

- In the rule, CMS states COVID-19 vaccine administration charges will be reimbursed similarly to existing vaccine administration HCPCS codes
  - For reference: G0008, G0009 and G0010 have a national unadjusted reimbursement rate of $38.11

- CMS states it expects it will create unique codes for each COVID-19 vaccine product
  - Once created, codes will be announced via traditional channels (MLN Articles, etc.) and be posted to the CMS website

Medicare Advantage & Medicare Cost Plans: COVID-19 Vaccine Coverage

- Medicare Advantage (MA) & Medicare Cost plans must cover all benefits covered by traditional Medicare
  - As Medicare is covering COVID-19 vaccines, so must MA and Cost plans

- MA plans are prohibited from charging cost sharing that is greater than what the beneficiary would be responsible for under traditional Medicare
  - $0 patient responsibility under Medicare = $0 patient responsibility under MA plans

- Historically, Cost plans are not prohibited from applying beneficiary cost-share to preventative services
  - CMS-9912-IFC mandates Cost plans to cover COVID-19 vaccinations and their administration services with no beneficiary responsibility when furnished by an in-network provider
  - This mandate for Cost plans is only effective for the duration of the declared Public Health Emergency (PHE)

Medicaid Beneficiaries: COVID-19 Vaccine Coverage

- For the duration of the declared COVID-19 PHE, the federal government is offering state Medicaid agencies a temporary 6.2 percentage point increase via the Federal Medical Assistance Percentage (FMAP) program

- One condition for receiving the increase is that the state must cover COVID-19 vaccines and their administration to Medicaid beneficiaries without cost-sharing
  - "CMS is not aware of any states or territories not currently claiming this temporary FMAP increase, or of any state or territory that intends to cease claiming it."

- Therefore, most Medicaid beneficiaries will have no cost-sharing responsibility for COVID-19 vaccines and their administration for the duration of the declared PHE

- In the IFC, CMS outlines a variety of ways states could choose to permanently cover COVID-19 vaccines with no cost-sharing responsibility for all Medicaid beneficiaries
  - These decisions will be made on an individual state by state basis

Private Health Plans: COVID-19 Vaccine Coverage

- Public Health Service (PHS) Act, Section 2173 (2015):
  - Non-grandfathered health insurance issuers must cover certain specified preventative items and services without cost-sharing
    - Vaccines must be covered 1 year after:
      - The vaccine is given a rating of "A" or "B" from United States Preventative Services Taskforce (USPSTF), or
      - The vaccine is recommended by the Advisory Committee on Immunization Practices (ACIP), the ACIP recommendation is accepted by the CDC, and the vaccine is added to CDC Immunization Schedules
  - No requirement to cover preventative services when furnished by an out-of-network provider (unless the plan does not have an in-network provider who can provide the service)
  - Insurers must cover all items and services "integral" to the qualifying preventative service with no cost-share responsibility
    - E.g. administration services for a qualifying vaccine, specimen collection for a qualifying lab test, etc.

- CARES Act (Mar 2020):
  - Health insurance issuers must cover, without cost sharing, qualifying coronavirus preventative services
  - Uses the same criteria as PHS Act to define covered vaccinations
  - COVID preventative services must be covered no later than 15 business days following an applicable recommendation
  - No sunset date for these requirements

Private Health Plans: COVID-19 Vaccine Coverage

- CMS-9912-IFC (Oct 2020):
  - Removes the requirement that a COVID vaccine must be added to the CDC Immunization Schedule in order to be considered a qualifying preventative service
    - The vaccine is given a rating of "A" or "B" from United States Preventative Services Taskforce (USPSTF), or
    - The vaccine is recommended by the Advisory Committee on Immunization Practices (ACIP), the ACIP recommendation is accepted by the CDC, ~~and the vaccine is added to CDC Immunization Schedules~~
  - Requires plans to cover COVID preventative services without cost-share responsibility whether the service is furnished by an in-network or out-of-network provider
  - If COVID preventative services are provided by an out-of-network provider the plan must reimburse the out-of-network provider a "reasonable rate"
    - Per CMS, the Medicare allowed amount would be a "reasonable rate" for health insurers to reimburse out-of-network providers
    - CMS wants to prevent patients from being "balance-billed" for out-of-network COVID preventative services
  - The CMS amendments noted above are only applicable for the duration of the declared PHE

Price Transparency for COVID-19 Diagnostic Tests

Price Transparency COVID-19 Tests: Overview

- CARES Act (Mar 2020):
  - Established a requirement that all providers who offer COVID-19 diagnostic tests publish the cash prices for these tests on their public websites for the duration of the declared PHE

- CMS-9912-IFC (Oct 2020):
  - Clarifies terms used in the CARES Act
  - Defines specific provider website requirements
  - Expands on the required data elements that must be posted
  - Outlines the penalty process for providers found to be non-compliant

Price Transparency COVID-19 Tests: Definitions

- **“Diagnostic Test for COVID-19”: All in vitro tests utilized for the detection of SARS-CoV-2 or the diagnosis of COVID-19**
  - Tests can be molecular, antigen and/or serological
  - CMS provides the following examples (not an exhaustive listing) of billing codes that meet this definition; 86408, 86409, 87635, 87426, 86328, 86769, U0001-U0004

- **“Provider of a diagnostic test for COVID-19”: Any facility that performs one or more COVID-19 diagnostic test**
  - Physician’s office, urgent care center, outpatient hospital, stand-alone lab, etc.
  - CMS reminds providers that in order to perform COVID-19 testing, the provider must hold a Clinical Laboratory Improvement Amendments (CLIA) certificate
    - Reminder - even “CLIA-waived” tests require a CLIA Certificate of Waiver (CoW)

- **“Cash Price”: The charge that applies to an individual who pays in cash (or cash equivalent) for a COVID-19 diagnostic test**
  - Commonly referred to as the “self-pay rate”
  - Analogous to the “discounted cash price” in the Hospital Price Transparency final rule

Price Transparency COVID-19 Tests: Requirements

- COVID-19 price transparency information must be displayed on your public website in an “easily accessible manner, without barriers”
  - Information must be accessible free of charge
  - Cannot require patients to create a user account or password
  - Cannot require patients to submit personal identifiable information

- “In addition, we are requiring that the provider’s homepage contain certain keywords that we believe will increase the likelihood that the public will be able to locate the information using a search engine”
  - All of the following term’s must be included on the provider’s homepage:
    - The provider’s name
    - “Price”
    - “Cost”
    - “Test”
    - “COVID”
    - “Coronavirus”

*Within the IFC CMS specifically asks for comments on whether providers should be allowed to use Cost/Price, and COVID/Coronavirus interchangeably

Price Transparency COVID-19 Tests: Requirements

- "We believe that it is important for the provider to include certain standardized information so that the public can understand the relationship between the posted cash price and the COVID-19 diagnostic test(s) offered by the provider"

- **Therefore, in addition to the cash price information, CMS will also require providers to post:**
  - A plain language description of each COVID-19 test the facility offers,
  - The corresponding cash price for each test,
  - The corresponding billing code for each test, and
  - "Any additional information necessary for the public to be certain of the cash price for a particular COVID-19 test"
    - Example: If the provider has multiple service locations, and the cash price differs based on location, this distinction will need to be made clear on the provider's website

- "**These requirements are applicable immediately**; however, we seek comment on these requirements and may, as a result of public comment, revise these requirements or finalize additional requirements."

Price Transparency COVID-19 Tests: Requirements

- Not having a public website does not exempt providers from the COVID-19 price transparency requirements

- Providers who do not have a website (e.g. small/rural providers, “pop-up” testing sites, etc.) must:

  - Display prominent signage at their service location with *all* required price transparency data points
    - E.g. plain language description for each test, cash price for each test, billing code for each test, and any “additional” information

  - Upon request, provide *all* required price transparency data points to the requestor in writing within 2 business days
    - CMS will consider email correspondence as an acceptable written format for providing this information

Price Transparency COVID-19 Tests: Penalty Process

- CMS states it will predominantly rely on complaints from the public to identify potentially non-compliant providers

- If upon investigation CMS confirms the provider is non-compliant with the regulations, CMS will take the following steps:
  - Provide a written warning notice to the provider outlining the specific regulation violations
  - Request that the provider submit and comply with a corrective action plan (CAP)
  - If the provider does not submit a CAP or does not comply with their CAP a civil monetary penalty of $300 per day will be imposed

Tying COVID-19 Testing Reimbursement to Turn-Around-Times

Tying COVID-19 Testing Reimbursement to Turn-Around-Times

- Effective January 1, 2021, CMS will reduce the reimbursement rate for high-throughput COVID tests U0003 & U0004 from $100 per unit to $75 per unit
  - Providers who perform these tests within 2 calendar days will be eligible for an additional add-on payment of $25 per
  - Craneware Rapid Fire Q&A on this topic:
    - https://public.craneware.com/news/covid-19-coding-and-billing/is-cms-changing-the-way-it-will-reimburse-providers-for-covid-19-lab-tests-that-utilize-high-throughput-technology

- CMS-9912-IFC:
  - "The Departments encourage plans and issuers to explore using payment arrangements that create incentives for providers to reduce the time it takes to provide results for diagnostic testing for COVID-19, while maintaining the accuracy rates of their test results in instances where it is within the ability of providers to address a delay"

  - "Encourage" not require (at least for now)

New COVID– 19 Treatments Add-on Payment (NCTAP) for Inpatient Medicare Claims

NCTAP Add-On Payment – IPPS Claims

- CMS has created a New COVID-19 Treatment Add-On Payment (NCTAP) for COVID inpatient claims that meet all of the following 3 criteria:

1) A drug or biologic authorized by the FDA to treat COVID-19 must be used during the case,

- Currently, there are only 2 products that meet this criterion – convalescent plasma and Remdesivir

2) The case must be eligible for the existing 20 percent increase to the DRG weighting factor, and

- Diagnosis code U07.1 must be reported on the claim
- The patient must have a documented positive COVID test in the medical record (CMS says it will audit for this)
- Craneware Q&A on this topic: https://public.craneware.com/news/covid-19-coding-and-billing/does-a-patient-need-a-positive-covid-19-lab-test-to-receive-the-additional-20-percent-increase-of-the-ms-drg

3) The cost of the case must exceed the operating federal payment under IPPS

- "The primary purpose of this criterion is to ensure that the NCTAP is made only when needed"
- CMS formula for calculating operating federal payment rates and outlier payments
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service Payment/AcuteInpatientPPS/Downloads/outlier_example_fy07.zip
- The formula contains variables that will differ from case to case and from hospital to hospital
  - E.g. your hospital's specific cost to charge ratio, your hospital's specific wage index, total eligible charges on each claim, DRG assigned to the claim, etc.

NCTAP Add-On Payment – IPPS Claims

- Claims will also be required to contain the corresponding ICD-10 PCS code for the eligible COVID treatment
  - Remdesivir
    - XW033E5 - Introduction of Remdesivir Anti-infective into Peripheral Vein, Percutaneous Approach, New Technology Group 5
    - XW043E5 - Introduction of Remdesivir Anti-infective into Central Vein, Percutaneous Approach, New Technology Group 5
  - Convalescent Plasma
    - XW13325 - Transfusion of Convalescent Plasma (Nonautologous) into Peripheral Vein, Percutaneous Approach, New Technology Group 5
    - XW14325 - Transfusion of Convalescent Plasma (Nonautologous) into Central Vein, Percutaneous Approach, New Technology Group 5

- If all NCTAP eligibility requirements are met, providers will receive an add-on payment amount equal to the lesser of:
  1) 65% of the operating outlier threshold for the claim, or
  2) 65% of the amount by which the costs of the case exceed the standard DRG payment (including the 20% relative weight adjustment)

NCTAP Add-On Payment – IPPS Claims

- NCTAP policy is “effective for discharges occurring on or after the effective date of this rule and until the end of the public health emergency”
  - NCTAP add-on payment policy is not retroactive

- In the IFC CMS reminds providers that they can not charge for treatments (COVID-19 related or otherwise) that the provider receives at no cost

- CMS reminds providers that all statutory requirements will still apply
  - E.g. the patient’s medical record must demonstrate that the COVID treatment was reasonable and medically necessary

Separate Payment for New COVID–19 Treatments for Outpatient Medicare Claims

Separate Payment for New COVID-19 Treatments – OPPS Claims

- Under OPPS, drugs that are not considered to be packaged (e.g. those assigned to status indicator K or G) are generally separately reimbursed on most outpatient claims

- The one exception to this rule → when non-packaged drugs are billed in conjunction with a Comprehensive APC (C-APC)
  - C-APC primary services are assigned status indicator J1

- As to not financially de-incentivize providers from furnishing COVID treatments, CMS will make an exception to it's C-APC packaging policy to ensure separate payment for outpatient COVID treatments that meet certain criteria (outlined on next slide)

- This separate payment policy will only be in effect for the duration of the declared PHE

- As C-APCs are generally surgical in nature, CMS does not believe it will be common for patients to receive a C-APC service and a COVID treatment during the same outpatient encounter
  - One exception may be C–APC 8011, "Comprehensive Observation Services"

Separate Payment for New COVID-19 Treatments – OPPS Claims

- 2 criteria COVID treatments must meet in order to be reimbursed separately when billed in conjunction with a C-APC:
  1) The treatment must be a drug or biological product (which could include a blood product) authorized to treat COVID-19, and
  2) The FDA approval/emergency use authorization for the drug or biological product (which could include a blood product) must:
     - Authorize the use of the product in the outpatient setting, or
     - Not limit its use to the inpatient setting

- "To date, no drug or biological product has an EUA for the treatment of patients with COVID-19 in the outpatient setting"*
  - Both Remdesivir and Convalescent Plasma only approved for inpatient use
  - *Breaking News 11-10-20: FDA grants EUA for Bamlanivimab to treat mild-to-moderate cases of COVID-19 in non-hospitalized patients

- In the IFC CMS reminds providers that all statutory requirements will still apply
  - E.g. the patient's medical record must demonstrate that the COVID treatment (once developed/approved) was reasonable and medically necessary

Action Plan – Next Steps

Action Plan – Next Steps

- ✓ Start reviewing financial impact of providing a COVID vaccine at your facility
  - What does your patient population look like?
  - Does your state have a COVID-19 vaccination plan?
  - Contact plans who you do not have contracts with to begin negotiations on a “reasonable” rate for out-of-network vaccination services

- ✓ Ensure your website is updated to include the new required data elements related to pricing transparency for COVID diagnostic tests

- ✓ Be on the look-out for commercial insurance plans starting to tie COVID test reimbursement to test turn-around-time

- ✓ Make sure your HIM department is reviewing the medication administration record for your COVID inpatients
  - Convalescent plasma and Remdesivir ICD-10 PCS codes need to be assigned appropriately in order to qualify for the NCTAP add-on payment

Questions on CMS-9912-IFC?

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COVID-19 Billing and Coding FAQs

Q: Now that Remdesivir has FDA approval should we bill for this drug using HCPCS code C9399?

Remdesivir – C9399?

- CMS Claims Processing Manual, Chapter 17:
  - "HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a specific HCPCS code has not been assigned"

- FDA Approval Letter for Remdesivir:
  - "Today, the U.S. Food and Drug Administration approved the antiviral drug Veklury (remdesivir)…for the treatment of COVID-19 **requiring hospitalization**."

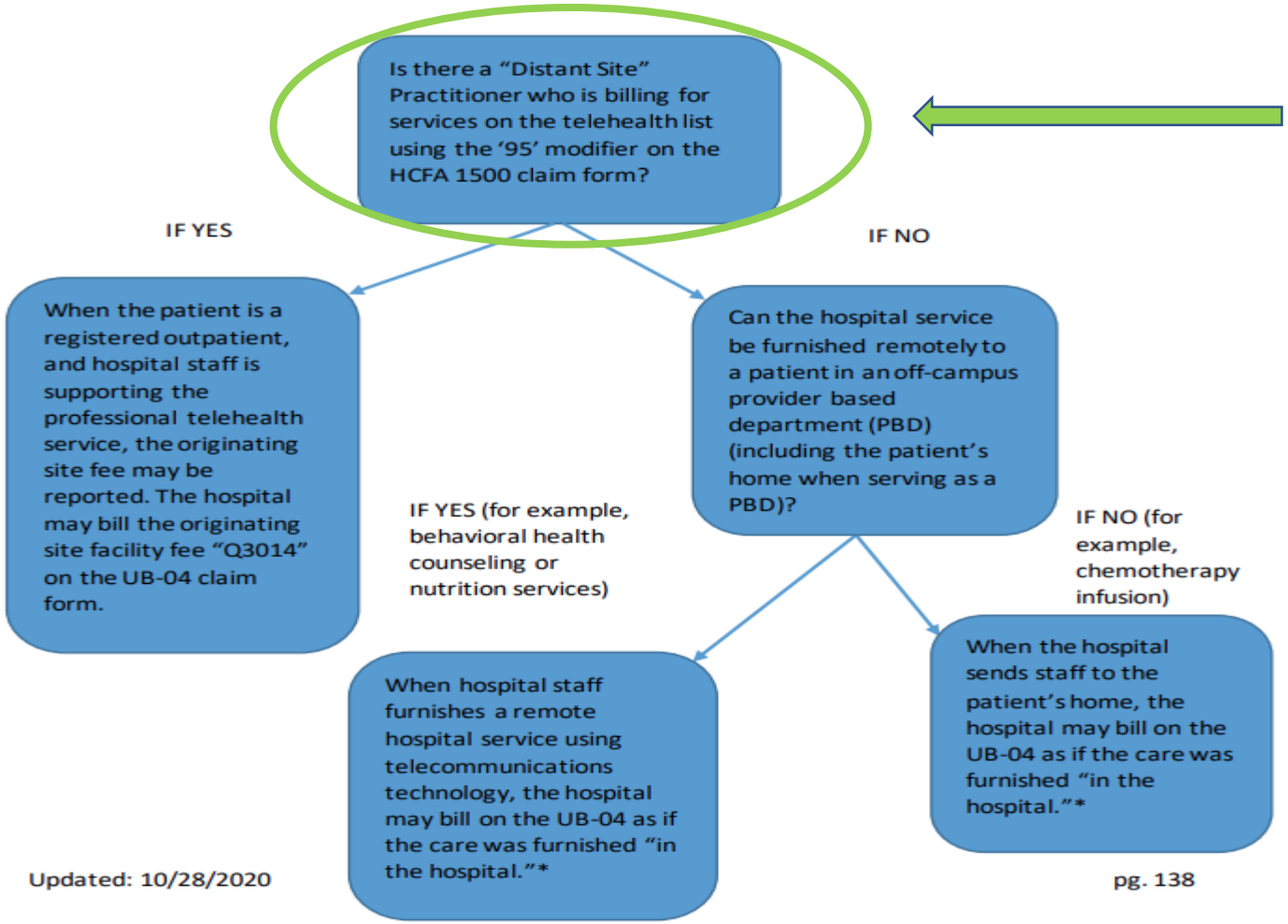
- Uniform Billing Editor (UBE):
  - "RC 0636 is not valid for inpatients claims except when used to bill hemophilia clotting factors"

A: Remdesivir does meet the HCPCS definition of C9399. However, as the drug is only approved for use in the inpatient setting – and neither revenue code 636 or HCPCS C9399 are reported on inpatient claims – it's likely not necessary to assign HCPCS C9399 for chargemaster/billing purposes.

Q: We're still not clear on when we should be charging Q3014 vs G0463 for hospital clinic "telehealth visits" – can you provide any additional guidance?

Q3014 vs G0463

- CMS COVID Billing FAQ:
  - https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf



- The decision between Q3014 vs G0463 hinges on whether or not the service qualifies as a Medicare telehealth visit
- Just because a service was furnished via telecommunications technology **does not mean it qualifies as a telehealth visit**

Q3014 vs G0463

- What are the requirements for a visit to be considered telehealth?

1) Eligible beneficiary (for the duration of the PHE all Medicare beneficiaries),

2) Eligible professional practitioner (for the duration of the PHE all practitioners that can independently bill Medicare),

3) The service provided by the professional practitioner is on the CMS list of approved professional telehealth services, **AND**
   - https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip

4) **The beneficiary and the professional provider must be at separate, distant sites while the service is being furnished**

Q3014 vs G0463

- CMS 1135 Hospitals Without Walls waiver allows hospitals to make a patient's home (or any other location) a temporary expansion site of the hospital
  - **This makes the patient's home part of your hospital** – not viewed any differently than if the patient was physically sitting in the clinic

Beneficiary is in their home which has been made a temporary expansion site of your hospital = **Patient considered to be "in your hospital"**

+

Provider is physically sitting in your hospital clinic = **Provider considered to be "in your hospital"**

=

Patient & Provider are both considered to be "in your hospital" when the service is provided = **service DOES NOT meet the CMS definition of a telehealth visit**

- In this scenario the beneficiary and provider are **not** considered to be at separate, distant sites (requirement #4 on previous slide):
  - Provider cannot use modifier 95 on their professional claim
  - Hospital cannot report Q3014 on their technical claim

Q3014 vs G0463

- When Q3014 is not appropriate review for G0463, or other appropriate codes
  - Virtual outpatient therapy, education, and training services can be provided and billed on a UB as though the service was furnished directly in the hospital
    - A sample (not an exhaustive listing) of codes that fall into this category:
      - https://www.cms.gov/files/zip/covid-ifc-2-list-hospital-outpatient-services.zip

- One caution:
  - G0463 and Q3014 are not interchangeable codes/services
    - Q3014 = "administrative and clinical support" provided during a telehealth visit
    - G0463 = Hospital outpatient clinic visit for assessment and management of a patient
  - Does the documentation in the hospital medical record support a facility charge for G0463?

A: The decision on whether to report Q3014 vs G0463 depends on whether the service provided meets the CMS definition of a "telehealth" encounter. If it does, HCPCS Q3014 should be reported by the hospital. If it does not, HCPCS G0463 or another appropriate code(s) should be reviewed.

Q: When and to what services should we be appending modifier “CS”?

“CS” Modifier

- The CARES Act required “COVID-19 testing related services” to be covered by Medicare with no beneficiary cost-sharing

- When applied, the “CS” modifier waives beneficiary cost-share
  - The service will be reimbursed by CMS at 100% of the allowed amount

- Per CMS, eligible “COVID-19 testing related services” are **E&M services** where;
  - **A COVID-19 test is ordered during the encounter, or**
  - **A COVID-19 test is administered during the encounter**

- There are no restrictions as to which type of COVID test must be ordered/administered

“CS” Modifier

- CMS list of CPT/HCPCS codes that are eligible for “CS” modifier if criteria outlined on the previous slide are met:
  - OPPS Claims: https://www.cms.gov/files/document/cs-waiver-opps-codes.pdf
  - MPFS Claims: https://www.cms.gov/files/zip/cs-modifier-hcpcs-codes-physicians-non-physician-practitioners.zip
    - Source – MLN SE20011
      - https://www.cms.gov/files/document/se20011.pdf

- Laboratory tests, including COVID-19 lab tests, already have no beneficiary cost-share under Medicare

A: Modifier “CS” should be appended only to eligible E&M codes and only in those instances when a COVID test is ordered or administered during the course of the encounter.

Q: What about modifier CR and condition code DR? When do we append those?

“CR” Modifier and “DR” Condition Code

- CR modifier and DR condition code are appended when Medicare payment is conditioned on the presence of a formal waiver (aka 1135 waiver)
  - CMS Coronavirus Waivers Homepage: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

- **Modifier CR**
  - Can be used on professional and facility claims
  - Appended at the individual CPT/HCPCS code level
  - Example: A patient requires a replacement DME device. This generally requires a face-to-face assessment, new order and new medical necessity documentation. CMS is waiving these requirements for replacement DME equipment for the duration of the PHE. Payment for the replacement device is conditioned on the presence of the DME waiver. Append modifier CR to the DME HCPCS code.

- **Condition Code DR**
  - Only for facility claims
  - Appended at the claim level
  - Example: You make the patient’s home a temporary expansion site of your hospital by utilizing the Hospital Without Walls waiver. The waiver allows you to provide services remotely to the patient in their home. Without the waiver, you would not be paid for these remote services. Your payment is conditioned on the presence of the waiver. Append condition code DR to this claim.

“CR” Modifier and “DR” Condition Code

- CMS MLN Matters Article SE20011:
  - CR/DR chart for providers
    - https://www.cms.gov/files/document/se20011.pdf

  - “Please note that CMS will not deny claims due to the presence of the “CR” modifier or “DR” condition code for services/items related to a COVID-19 waiver that are not on this list, or for services/items that are not related to a COVID-19 waiver. There may be potential claims implications, such as claims denials, for claims that do not contain the modifier or condition code as required in the below chart.”

A: Modifier “CR” should be appended to individual CPT/HCPCS codes when the payment for that code is dependent on the presence of an 1135 waiver. Condition code “DR” should be appended at the claim level if payment for the claim is dependent on an 1135 waiver. It is important to note that CMS states it will not penalize providers for over-applying the modifier/condition code. However, there may be penalties if the modifier/condition code is required and is not reported on your claims.

Q: What's the deal with new CPT code 99072? Should we be reporting this code to account for extra resources used during the PHE?

CPT 99072

- On September 8, 2020, the AMA announced the creation of new CPT code 99072
  - **99072: Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease**

- Code will only be active for the duration of the declared PHE

- The code captures the following additional practice expenses:
  - Time over what is included in the primary service
  - 3 surgical masks
  - Cleaning supplies, including additional quantities of hand sanitizer, disinfectant wipes, sprays, and cleaners

- **Per the AMA, "This new code should only be reported when the service is rendered in a non-facility place of service (POS) setting"**

CPT 99072

- CMS has assigned the following indicators to CPT 99072
  - OPPS Claims
    - Status Indicator B = “Not recognized by OPPS when submitted on an outpatient hospital Part B bill type”
  - PFS Claims
    - Status Code Indicator B = “No separate payment is ever made”

- Also not likely to be separately reimbursed by commercial insurers
  - Cigna:https://static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalDoingBusinessWithCigna/medicalDbwcCOVID-19.html
  - Wellmark: https://www.wellmark.com/Provider/CommunicationAndResources/COVID-19/FAQ.aspx
  - Blue Cross of Mass: https://provider.bluecrossma.com/ProviderHome/wcm/connect/bd17444e-525d-4027-978c-a3cf3c39c2ad/COVID-19_Public_Health_Emergency_payment_policy.pdf?MOD=AJPERES

A: Professional providers may choose to report CPT 99072. However, the code carries no additional reimbursement under Medicare, and is unlikely to be reimbursed separately by commercial payers.

Q: Why doesn’t new COVID lab test CPT XXXXX have an assigned status indicator? How much will we be reimbursed for this new test?

New COVID Lab CPTs – What's the SI and reimbursement rate?

- Code Availability:
  - Different code sets are maintained by different organizations
    - HCPCS Codes - Maintained by CMS
    - CPT and Laboratory PLA Codes - Maintained by the AMA
  - These organizations do consult with one another, but do not coordinate code set releases
  - CMS' Clinical Laboratory Fee Schedule (CLFS) is typically updated quarterly
    - In response to the PHE, CMS has added new lab codes to it's claims processing system on a more frequent, as-needed basis
  - CMS has generally backdated the Medicare effective date of all off-cycle CPT and PLA codes to the date the code was announced by the AMA

New COVID Lab CPTs – What's the SI and reimbursement rate?

- Reimbursement:
  - National CLFS rates are typically established by CMS through annual rule making
  - "Local MACs are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes and the CPT code in their respective jurisdictions until Medicare establishes national payment rates on the CLFS"
  - New COVID lab codes will show with a status indicator of "L" and rate of $0 in the CLFS until a national rate is established
    - This does not mean you will not be reimbursed for these tests

A: As CPT and PLA codes are maintained by the AMA and not CMS - there will generally always be a delay from the time a new code is announced by the AMA to when the code is added to the Medicare claims processing system. All new off-cycle lab codes will be priced by your individual MAC until a national rate can be established. We recommend checking your MAC website regularly for new/updated reimbursement rates for these codes.

Trisus Pricing Transparency

Available at no charge to US hospitals

Easy to implement

- No charge, no fees
- Limited hospital IT requirements
- Fast 3-4 week turnaround from signed agreement & receipt of required data

Benefits you receive in return for this government mandate

- Quarterly analytics reporting to:
  - Gain insights on which services are being searched (consumer behavior)
  - Inform overall pricing strategy for price rebalancing as needed
  - Reduce middle layer of payor control – can directly see what patients need vs depending on payor for that data
  - Ensure compliance and market competitiveness

Craneware's purpose is to impact healthcare profoundly by improving healthcare providers' operational efficiency and margin, so they can continue investing in providing quality care for their communities.

Learn more at craneware.com/transparency

Additional COVID Coding and Billing Questions?

Together, We are Craneware®