Delegated Provider Portal Postings Effective 11.19.19 – 4.1.20

CMS:

CMS Ensuring Customer Service Reps are prepared to Support Dually Eligible Enrollees Effective 1.1.20:

CMS has noted a correction on page 2, under "Ensuring Sufficient Access to OTP Providers," to the correct webpage link that CMS will update bi-weekly (i.e., with the posted list of OTP providers who have submitted applications to enroll with Medicare, as well as those whose applications have been approved). The correct link is https://nam03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdata.cms.gov%2F&data=02%7C01%7Ctbeyl%40humana.com%7Ce1b129ea2e704151945c08d78fd25b6c%7C56c62bbe85984b859e511ca753fa50f2%7C1%7C0%7C637136005958367088&sdata=DL4lqIWuOBbfpTX7LY1Z8eEwiY5MUxyLfysfmFpebGo%3D&reserved=0.

CMS Dually Eligible Enrollees – Cost-Sharing Liability and Protections Effective 1.1.20:

CMS has noted a correction on page 2, under "Ensuring Sufficient Access to OTP Providers," to the correct webpage link that CMS will update bi-weekly (i.e., with the posted list of OTP providers who have submitted applications to enroll with Medicare, as well as those whose applications have been approved). The correct link is https://nam03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdata.cms.gov%2F&data=02%7C01%7Ctbeyl%40humana.com%7Ce1b129ea2e704151945c08d78fd25b6c%7C56c62bbe85984b859e511ca753fa50f2%7C1%7C0%7C637136005958367088&sdata=DL4lqIWuOBbfpTX7LY1Z8eEwiY5MUxyLfysfmFpebGo%3D&reserved=0

CMS Ensuring Sufficient Access to OTP Providers Effective 1.1.20:

https://data.cms.gov/browse?q=OTP

CMS has noted a correction on page 2, under "Ensuring Sufficient Access to OTP Providers," to the correct webpage link that CMS will update bi-weekly (i.e., with the posted list of OTP providers who have submitted applications to enroll with Medicare, as well as those whose applications have been approved). The correct link is https://nam03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdata.cms.gov%2F&data=02%7C01%7Ctbeyl%40humana.com%7Ce1b129ea2e704151945c08d78fd25b6c%7C56c62bbe85984b859e511ca753fa50f2%7C1%7C0%7C637136005958367088&sdata=DL4lqIWuOBbfpTX7LY1Z8eEwiY5MUxyLfysfmFpebGo%3D&reserved=0

CMS Continuity of Care and Transition Process Effective 1.1.20:

CMS has noted a correction on page 2, under "Ensuring Sufficient Access to OTP Providers," to the correct webpage link that CMS will update bi-weekly (i.e., with the posted list of OTP providers who have submitted applications to enroll with Medicare, as well as those whose applications have been approved). The correct link is https://nam03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdata.cms.gov%2F&data=02%7C01%7Ctbeyl%40humana.com%7Ce1b129ea2e704151945c08d78fd25b6c%7C56c62bbe85984b859e511ca753fa50f2%7C1%7C0%7C637136005958367088&sdata=DL4lqIWuOBbfpTX7LY1Z8eEwiY5MUxyLfysfmFpebGo%3D&reserved=0

CMS Dept of Treasury Prompt Payment Interest Rate; Contract Disputes Act Effective 1.1.20:

The Department of the Treasury has published the clean claims interest rate for Medicare Advantage non-affiliated providers and/or Private Fee for Service providers for clean claims which are not processed within 30 calendar days of receipt. Medicare says that a claim is defined as paid on the date the check is mailed.

- The rate for the period of January 1 through June 30, 2020 is 2.125 percent.
- The rate for the period of July 1 through December 31, 2019 was 2.625 percent.

Part D has a similar requirement to process clean electronic claims within 14 days of receipt and other clean claims within 30 days of receipt. The plan must give notice of a deficiency to the network pharmacy within 10 days of receipt of an electronic claim or within 15 days for other claims, or the claim is automatically considered clean. Interest on clean claims is at a rate equal to the weighted average of interest on three month marketable Treasury securities for the period and increased by 0.1 percentage point as of the day after the payment date required and ending on the day payment is made. Included in the following web address is one of the payment calculators from the Treasury electronic site: http://fms.treas.gov/prompt/calculations.html

CMS Notification – MED Distribution Files – December 2019 Effective 12.1.19:

While providers are under sanction, no payment may be made for claims other than emergency services not provided in a hospital emergency room. No payment may be made to a business or other entity on behalf of an excluded provider. Beneficiaries are free to choose these providers, but they must understand that organizations and plans may not make payment. The current month's MED files are available for download from the MFT Internet Server at:https://eftp2.cms.hhs.gov:11443/

The excluded provider data is also available in an online application at: https://med.cms.gov/

These files have a retention period of 30 days.

CMS Transmittal – January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0 Effective 1.1.20:

This notification provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that will be utilized under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness.

The I/OCE specifications are posted to the CMS Website at:

http://www.cms.gov/OutpatientCodeEdit/

The summary of changes begins on page five of the attached document, effective January 1, 2020.

CMCS Informational Bulletin: Guidance for State Medicaid Agencies on Dually Eligible Beneficiaries Receiving Medicare Opioid Treatment Services Effective 1.1.20:

Starting **January 1, 2020**, Medicare will begin paying for opioid treatment programs (OTPs) through bundled payments for opioid use disorder (OUD) treatment services, including medication-assisted treatment (MAT) medications, toxicology testing, and counseling as authorized under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).

For dually-eligible beneficiaries who receive OTP services through Medicaid now, starting January 1, 2020, Medicare will become the primary payer for OTP services.

CIB: Guidance for State Medicaid Agencies on Dually Eligible Beneficiaries Receiving Medicare Opioid Treatment Services Effective January 1, 2020

CMS Transmittal – New Medicare Provider Specialty Code (D5) and Billing Codes for Opioid Treatment Programs and New Place of Service Code (58) Effective 1.1.20:

Update 12.30.19

Transmittal 4472, dated December 5, 2019, is being rescinded and replaced by Transmittal 4486, dated, December 27, 2019, to replace attachment A (G-codes with Payment Adjusted by Locality) with a new spreadsheet. All other information remains the same.

Original

CMS states in the attached document that All Opioid Treatment Programs billing Medicare will be required to enroll with Medicare as an Opioid Treatment Program and submit claims to MCS using a professional claim form.

Transmittal 4472 updates the current place of service (POS) code set by adding new place of service POS code 58 for "Nonresidential Opioid Treatment Facility – a location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT)." The transmittal will also implement the systems and local contractor level changes needed for Medicare to adjudicate claims with the new POS code. Local contractors shall develop policies as needed to adjudicate claims containing new POS code 58 in accordance with Medicare national policy.

All polices are subject to change pending the publication of the final payment policies in the CY 2020 PFS final rule. If there are changes to these proposed policies made in response to public comments in the final rule, CMS will provide further instruction.

CMS Transmittal - Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment Effective 1.1.20:

https://www.cms.gov/cms-search?search=Clinical+Lab+Fee+Schedule&field_date%5Bmin%5D=&field_date%5Bmax%5D=&sort_by=search_api_relevance&items_per_page=10

CMS Transmittal - April 2020 Healthcare Common Procedure Coding System (HCPCS) Quarterly Update Reminder Effective 1.1.20:

https://www.cms.gov/cms-search?search=HCPCS&field_date%5Bmin%5D=&field_date%5Bmax%5D=&sort_by=search_api_relevance&items_per_page=10

CMS is advising their contractors that the April 2020 HCPCS file will be available for download in mid-February. CMS maintains a page on their website containing quarterly updates, release information and codes. The file contains existing, new, revised, and discontinued alpha-numeric codes for 2020.

The site address is:

https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

NOTE: CMS is now issuing this reminder quarterly, beginning with the April 2020 update. The previous notifications were issued on an annual basis.

59G-4.330 Non-Emergency Transportation Services – Final Effective 11.19.19:

59G-4.330 Non-Emergency Transportation Services

(1) This rule applies to all providers rendering Florida Medicaid non-emergency transportation services to recipients.

(2) All providers must be in compliance with the provisions of the Florida Medicaid Non-Emergency Transportation Services Coverage Policy, November 2019, incorporated by reference. The policy is available on the Agency for Health Care Administration's website at http://ahca.myflorida.com/Medicaid/review/index.shtml, and at http://www.flrules.org/Gateway/reference.asp?No=Ref-11228.

Also reference the attached Florida Non-Emergency Transportation Services Coverage Policy, November 2019, incorporated by reference, that contains the following sections:

- 1.0 Introduction
- 2.0 Eligible Recipient
- 3.0 Eligible Provider
- 4.0 Coverage Information
- 5.0 Exclusion
- 6.0 Documentation
- 7.0 Authorization
- 8.0 Reimbursement

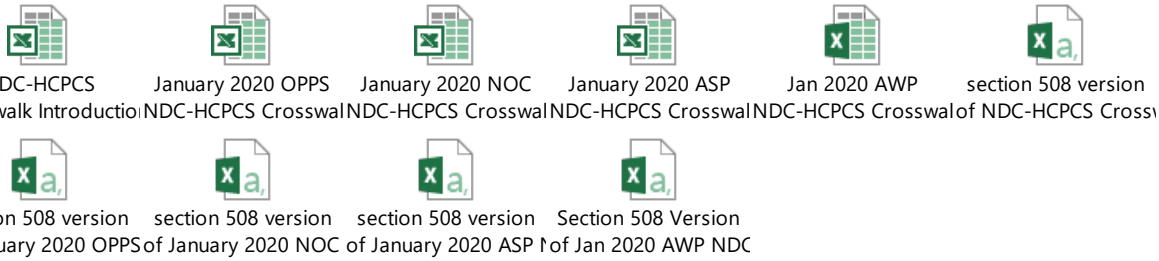
Pay particular attention to the following section on page 1:

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

See source documents, including coverage policy, for complete information.

CMS Website - January 2020 ASP Drug Pricing Files Effective 1.1.20:



GHHKQ96EN

CMS Website - 2019 ASP Drug Pricing Files - April 2019 Effective 4.1.19:

https://www.cms.gov/cms-search?search=ASP+Drug+Pricing&field_date%5Bmin%5D=&field_date%5Bmax%5D=&sort_by=search_api_relevance&items_per_page=10

CMS Website - 2019 ASP Drug Pricing Files Effective 11.27.19:

https://www.cms.gov/cms-search?search=ASP+Drug+Pricing&field_date%5Bmin%5D=&field_date%5Bmax%5D=&sort_by=search_api_relevance&items_per_page=10

CMS Transmittal - Instructions for Retrieving the 2020 Pricing and Healthcare Common Procedure Coding System (HCPCS) Data Files through CMS' Mainframe Telecommunications Systems Effective 1.1.20:

CMS is providing the annual update of the pricing and HCPCS data files instructions for retrieving the 2020 Pricing and HCPCS Data Files through CMS' Mainframe Telecommunications System (MTS).

CMS is advising their contractors to price claims with dates of service on and after January 1, 2020, with codes and fee rates furnished in the 2020 files. The following 2020 files will be available on or after November 4, 2019:

- Fee amounts for Clinical Diagnostic Laboratory services
- Fee amounts for DMEPOS
- Physician Fee Schedule abstract fee amounts for Outpatient Rehabilitation and CORF services
- Fee amounts for Part B hospice claims, outpatient rehabilitation, CORF, SNF and CAH services
- Physician Fee Schedule Payment Policy Indicator file for Method II CAH professional services
- Fee amounts for the new digital mammography technology and regular screening mammography services
- Fee amounts for Part B SNF claims
- Anesthesia conversion factor fee amounts for CAH services
- Ambulance fee amounts by locality for all localities

CMS - Federal Register - CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the

Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule (CMS-1715-F and IFC) Effective 1.1.20:

UPDATE - January 2, 2020

CMS has issued the attached document, CMS-1715-CN, correcting technical errors in the final rule that appeared in the November 15, 2019 Federal Register.

See attached source document for details.

UPDATE - December 6, 2019

The attached Transmittal, 4468, provides a summary of the policies in the CY 2020 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount.

NOTE:

In addition, CMS finalized the creation of two new HCPCS codes, G2082 and G2083, which will allow payment, on an interim final basis, under the Physician Fee Schedule for the use of Esketamine in services to patients with treatment-resistant depression during CY2020.

CMS Transmittal - Instructions for Downloading the Medicare ZIP Code Files for April 2020 Effective 4.1.20:

This instruction to the Medicare Contractors describes the process for updating the two Medicare ZIP Code files (ZIP5 and ZIP9) for the April 2020 quarter as well as the process for downloading the Calendar Year-End zip code files.

CMS issues an updated, 5-digit ZIP code file and 9-digit ZIP code file to its Contractors to be used for pricing Medicare claims. CMS will also post a list of the 5-digit ZIP codes that require a 4-digit extension, and a list of the most recent additions and deletions to that file on their website at:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html

This instruction describes the process for updating the Medicare ZIP Code files for the April 2020 Quarterly Update.

CMS - 40.12.1 - Part C Notification Requirements Pre-Service Approvals Effective 2.1.19:

Update - March 21, 2019

An updated Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance document has been posted on the CMS website:

https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/CoverageDeterminationsandExceptions.html

The CMS updated document along with a document comparing the February 22, 2019 with the updated March 21, 2019 documents is attached.

Update - February 22, 2019

HPMS sent a memo to announce the release of the final Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance on February 22, 2019. Along with the memo CMS also included a version (attached) showing changes from the draft released in October, 2018. The memo also includes a list of noteworthy changes from Chapters 13/18 to this revised guidance.

Original

The attached document covers the appeal provisions in 42 CFR Part 422 Subpart M and 42 CFR Part 423 Subparts M and U. It addresses grievances, coverage/organization determinations, and appeals for beneficiaries enrolled in a plan provided by a Medicare Advantage (MA) organization, a Medicare cost plan, health care prepayment plan (HCPP), or a stand-alone Part D plan.

Additional information related to Part C and Part D grievances, coverage/organization determinations, and appeals may be found on the following Appeals and Grievances guidance webpages:

https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html

http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/

Illinois:

Illinois Medicaid:

Illinois Medicaid Provider Notice: Rate Increases for Custom Orthotic and Prosthetic Devices Effective November1, 2019:

HFS has advised that effective with dates of service beginning November 1, 2019, the Department's maximum allowable rates for custom orthotic and prosthetic devices will be calculated based on the Medicare rate in effect on July 1, 2019, minus six percent (6%).

The Department's maximum allowable rates for new items added to the fee schedule after November 1, 2019 will be calculated based on the Medicare rate for the year the procedure code is first established on the Department's fee schedule, minus six percent (6%). All orthotic and prosthetic device services are subject to the 2.7% SMART Act rate reduction.

Actual payment for covered items is based on the lesser of the provider's charge or the maximum allowable rate established by the Department.

This update is published on the following webpage:

https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/DME.aspx

Reference source documents for complete information.

Massachusetts:

Massachusetts Bulletin 2019-07 Common Procedure Coding Systems for Opioid Agonist and Antagonist Treatment Effective 8.29.19:

A. OVERVIEW

Massachusetts Bulletin 2019-07 provides instructions to carriers, and guidance to contracting providers who initiate or continue opioid agonist and antagonist treatments regarding common procedure coding to be used when submitting claims for these treatments.

Tennessee:

Tennessee 56-32-129: Provider Discrimination Effective 7.1.17:

A. OVERVIEW

In 2017, Tennessee updated its law which prohibits discrimination against providers who are practicing within the scope of their license.

B. DEFINITION

"Class of providers" means optometrists, ophthalmologists, podiatrists, pharmacists, and chiropractors.

C. BACKGROUND

This summary pertains to a law that was amended in 2017 with an effective date of July 1, 2017. The original law was created in 2002 and has only been amended once, in 2017. In 2017, it was enacted under SB 461 and is now codified at TN 56-32-129. No prior review was completed on this law in 2002. In 2017, the update to the law would have only impacted pharmacists because pharmacists were added to the definition of class of providers, and therefore may have been completed by the PORTIA team. However, upon further review, this statute applies to other provider types with Humana's network. This statute is summarized below.

D. DISCRIMINATION AGAINST PROVIDERS PROHIBITED
56-32-129

- Insurers cannot discrimination with respect to participation, referral, reimbursement of covered services or indemnification as to any provider within a class of providers who is acting within the scope of the provider's license or certification under state law, solely on the basis of such license or certification.

- In selecting among providers in a provider network, the insurer must not discriminate against a class of providers who provide services that are covered by the plan by prohibiting such class of providers from membership in the provider network.

- This law is not to be construed as prohibiting insurers from including providers or classes of providers only to the extent necessary to meet the needs of the managed health insurance issuer's plan and its enrollees, or from limiting referrals or establishing any other measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

- This law is not to be construed as creating coverage for any service that is not otherwise covered under the terms of the insurer’s plan.