CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10043	**Date: April 9, 2020**
	Change Request 11516

Transmittal 10021, dated March 27, 2020, is being rescinded and replaced by Transmittal 10043, dated, April 9, 2020 to revise business requirement 11516.1, remove Part B and DME from the title and policy sections, and to remove the program indicator from the attachment. All other information remains the same.

SUBJECT: Implementation of Additional Requirement to add Healthcare Common Procedure Coding System (HCPC) and Current Procedural Terminology (CPT) - HCPC/CPT as Paired Items of Service for Prior Authorization and Medicare Claims Processing for Part A and Home Health and Hospice

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement the additional claims processing requirements for prior authorization programs and Medicare claims processing to add Healthcare Common Procedure Coding System (HCPC) and Current Procedural Terminology (CPT)-HCPCS/CPT as paired items of serivce for future processing. Adding the HCPCS/CPT as paired items of service is necessary to ensure the system knows where to identify new paired items of service when it is a HCPCS/CPT pair for future program files.

EFFECTIVE DATE: July 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 10043	Date: April 9, 2020	Change Request: 11516

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SUBJECT: Implementation of Additional Requirement to add Healthcare Common Procedure Coding System (HCPC) and Current Procedural Terminology (CPT) - HCPC/CPT as Paired Items of Service for Prior Authorization and Medicare Claims Processing for Part A and Home Health and Hospice

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I. GENERAL INFORMATION

A. Background: The Center for Program Integrity by itself and jointly with the Center for Medicare & Medicaid Innovation (CMMI) conducts demonstrations and model tests using prior authorization. This is done as part of the Centers for Medicare & Medicaid Services (CMS) approach to managing Medicare medical costs, reducing fraud, waste, and abuse, and protecting beneficiaries. This will compliment other, longer-term CMS efforts to reduce costs based on delivery system and payment reform while reducing the improper payment rate.

B. Policy: CMS conducts prior authorization programs on a series of items/services, in select states or nationally. The focus of this system modification is to add Healthcare Common Procedure Coding System and Current Procedural Terminology (HCPCS/CPT) as a combined item for future processing. Adding the HCPCS/CPT as paired items of service is necessary to ensure the system knows where to identify a new paired item of service when it is a HCPCS/CPT pair for future program files.

At a high level, the following explains the various prior authorization scenarios:

• When a requester submits a prior authorization request to the review entity with appropriate documentation and all relevant Medicare coverage and documentation requirements are met for the service, then an affirmed prior authorization decision is sent to the affected parties. When the claim is submitted to the Medicare Administrative Contractor (MAC), it is linked to the prior authorization and as long as all requirements in the applicable Medicare policies are met, the claim is paid.

• When a requester submits a prior authorization request but all relevant Medicare coverage and documentation requirements are not met for the service, then a non-affirmed prior authorization decision will be sent to the affected parties advising them that Medicare will not pay for the item. When the claim is submitted to the MAC for processing, it will be denied. The provider/supplier, facility, and/or the beneficiary can appeal the claim denial. All current Advanced Beneficiary Notice of Noncoverage policies would remain unaffected by this program.

• When a requester does not submit a prior authorization request, and thus does not receive a prior authorization decision, but a claim is still submitted to the MAC for processing, the claim will be subject to the requirements of the specific prior authorization program. The claim may be denied, suspended for medical review, or subject to another action. If a claim is denied, all appeal rights are available as they normally are.

CMS believes the high-level action steps in the process are as follows:

- Provider Action: Submits prior authorization request for an eligible service/items
- Review Entity Action: Receives request
- Review Entity Action: Makes decision
- System Action (initiated by review entity): Records decision
- Review Entity Action: Notifies affected parties
- Provider Action: Renders/delivers service/item
- Provider Action: Submits the claim

System Action: Match decision with submitted claim for Part A and Home Health & Hospice (HH&H)

• If decision is affirmed, pay so long as all other requirements are met

• If decision is non-affirmed, deny

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11516.1	Fiscal Intermediary Shared System (FISS) shall modify the Program File/Criteria to allow contractors to list up to 100 groupings of applicable paired items of service (IOS) for a Prior Authorization (PA) program, if any. NOTE: The attached Program File is an example for testing purposes only. An effective date will be provided at a later time.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Paired IOS are groups of two to six procedure codes (Health Care Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), *International Classification of Diseases* (ICD) -10, etc.) that the Centers for Medicare & Medicaid Services (CMS) has determined are related and should be subject to PA in conjunction with each other.									
11516.2	The SSMs shall modify the Program File/Criteria to maintain separate Medical Review (MR) counts for each paired IOS.					X			X	
11516.2.1	The SSMs shall modify their PA files to reflect separate MR counts for each paired IOS.					X			X	
11516.2.2	CWF shall accommodate reading separate MR counts when paired IOS are billed on the same claim with the same UTN to ensure appropriate editing for each IOS.								X	
11516.3	FISS shall not match any Prior Authorization Request (PAR) to a paired IOS PA program unless the PAR includes a valid pair of IOS. NOTE: The contractors should utilize existing logic for PARs that do not match to a PA program to process PARs that do not match a PA program because they do not include a valid paired IOS.					X				
11516.4	FISS shall assign the same Unique Tracking Number (UTN) to all related IOS on the PAR when a PAR includes a valid pair of IOS for a PA program.					X				
11516.5	The contractors shall assign the same review decision to all required procedure codes in a paired IOS.	X		X						
11516.6	FISS shall only match a claim to a paired IOS PA program when: • The claim includes a valid pair of IOS; • All paired IOS have the same Date of Service (DOS) as one another; and					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• All paired IOS have the same UTN as one another (if a UTN is present)									
11516.6.1	FISS shall assign all procedure codes that belong to a paired IOS on the same claim the same Program ID.					X				
11516.7	This business requirement has been deleted.									esMD

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jennifer McMullen, 410-786-7635 or jennifer.mcmullen@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 1

Prior Authorization Program Criteria Template

The below prior authorization program criteria must be identified for each PA program that is implemented. This criterion is entered into the shared system files by the Medicare Administrative Contractors (MACs). It is a user-controlled file.

PA Program Indicator	
PA Program Description	Prior Authorization (PA) for Certain Hospital Outpatient Department (OPD) Services
State *	All US States and Territories
Start Date of PA Program	Notice will be provided.
End Date of PA Program	Ongoing Program, no End Date
Designated Provider Indicator	
Provider Validation Indicator	
Railroad Board (RRB) Exclusion Indicator	
Item of Service (IOS) Pairs	64612 J0585 **or** 64612 J0586 **or** 64612 J0587 **or** 64612 J0588 **or** 64615 J0585 **or** 64615 J0586 **or** 64615 J0587 **or** 64615 J0588
Medical Review (MR) Count Indicator	NA
MR Count time period	Required on the initial PA setup. And 120 days after the receipt of the initial approval, provider will need to submit a new PA request. If a claim is submitted with a non-affirmed decision or no prior authorization decision on file, it should be denied. If a claim is billed for dates of service outside the MR period based on the HUPA, the claim should be denied.
Place of Service (POS) (Part B)	NA
Type of Bill (Part A)	013X
Provider Type (Part A) **Provider Specialty (Part B)**	00

HCPCS/ CPT/HIPPS	
Modifier	NA
ICD 9/10 Indicator	0
ICD 10 Procedure Code	NA
ICD 10 Diagnosis Code subject to PA	NA
Revenue Code	NA
Condition Code	NA
Occurrence Code	NA
Grace Period	NA
Payment Reduction	NA
Rep Payee **	NA