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July 2020 Update of the Ambulatory Surgical Center (ASC) Payment System

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Implementation Date: July 6, 2020

Note: We revised this article on July 2, 2020, to correct the last sentence in Section 6.e, on page 10. It should have stated, "C9058 is replaced by Q5120 effective July 1, 2020." All other information is unchanged

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services subject to the Ambulatory Surgical Center (ASC) Payment System and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article describes changes to and billing instructions for various payment policies implemented in the July 2020 ASC payment system update. This notification also includes updates to the HCPCS. Make sure your billing staffs are aware of these updates.

BACKGROUND

CR 11842 contains Calendar Year (CY) 2020 payment rates for separately payable procedures/services, drugs and biologicals, including descriptors for newly created Current Procedural Terminology (CPT) and Level II HCPCS codes. A July 2020 Ambulatory Surgical Center Fee Schedule (ASCFS) File, a revised January 2020 ASCFS file, a July 2020 Ambulatory Surgical Center Payment Indicator (ASC PI) File, a July 2020 Ambulatory Surgical Center Drug File, a July 2020 ASC Code Pair File, and a revised January 2020 ASC Code Pair File will be issued with CR 11842.

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

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The changes for July 2020 are as follows:

1. New CPT Category III Codes Effective July 1, 2020

The American Medical Association (AMA) releases CPT Category III codes twice per year:

- In January, for implementation beginning the following July
- In July, for implementation beginning the following January

Effective July 1, 2020, the Centers for Medicare & Medicaid Services (CMS) is implementing 11 CPT Category III codes in the ASC payment system that the AMA released in January 2020 for implementation on July 1, 2020. These codes, along with their short and long descriptors, and their ASC PIs are shown in Table 1. Updated payment rates, effective July 1, 2020, are available in the July 2020 update of ASC Addendum BB at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

Table 1. — New CPT Category III Codes Effective July 1, 2020

CPT Code	Long Descriptor	Short Descriptor	ASC PI
0594T	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device	Osteot hum xtrnl lngth dev	J8
0596T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); initial insertion, including urethral measurement	Temp fml iu vlv-pmp 1st insj	P2
0597T	Temporary female intraurethral valve-pump (ie, voiding prosthesis); replacement	Temp fml iu valve-pmp rplcmt	P2
0598T	Noncontact real-time fluorescence wound imaging, for bacterial presence, location, and load, per session; first anatomic site (eg, lower extremity)	Ncntc r-t fluor wnd img 1st	Z2
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous	Ire abltj 1+tum organ perq	J8
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open	Ire abltj 1+tumors open	J8
0614T	Removal and replacement of substernal implantable defibrillator pulse generator	Rmvl&rplcmt ss impl dfb pg	J8

CPT Code	Long Descriptor	Short Descriptor	ASC PI
0616T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; without removal of crystalline lens or intraocular lens, without insertion of intraocular lens	Insertion of iris prosthesis	J8
0617T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens	Insj iris prosth w/rmvl&insj	J8
0618T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens placement or intraocular lens exchange	Insj iris prosth sec io lens	J8
0619T	Cystourethroscopy with transurethral anterior prostate commissurotomy and drug delivery, including transrectal ultrasound and fluoroscopy, when performed	Cysto w/prst8 commissurotomy	J8

2. Hemodialysis Arteriovenous Fistula (AVF) Procedures: Replacement Codes for HCPCS Codes C9754 and C9755

For CY 2019, based on two separate new technology applications received for hemodialysis arteriovenous fistula creation, CMS established HCPCS code C9754 for the Ellipsys System and C9755 for the WavelinQ System in the Hospital Outpatient Prospective Payment System (OPPS) effective January 1, 2019. These codes were also implemented in the ASC payment system effective January 1, 2019, and included in the January 2019 ASC quarterly update (CR 11108 – See the related article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11108.pdf).

For the July 2020 update, CMS is deleting HCPCS codes C9754 and C9755 since they will be replaced with HCPCS codes G2170 and G2171, respectively, effective July 1, 2020. We note that the replacement G-codes have been assigned to the same ASC PIs as the predecessor HCPCS C-codes. Table 2 lists the HCPCS codes and long descriptors. Updated payment rates, effective July 1, 2020, are available in the July 2020 update of ASC Addendum BB at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

Table 2. — Replacement Codes for HCPCS Codes C9754 and C9755

HCPCS Code	Long Descriptor	Short Descriptor	Add Date	Term Date	Replacement Code
C9754	Creation of arteriovenous fistula, percutaneous; direct, any site, including all imaging and radiologic supervision and interpretation, when performed and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization, when performed)	Perc av fistula, direct	1/1/2019	6/30/2020	G2170
G2170	Percutaneous arteriovenous fistula creation (AVF), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed	AVF by tissue w thermal e	7/1/2020	N/A	N/A
C9755	Creation of arteriovenous fistula, percutaneous using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, when performed) and fistulogram(s), angiography, venography, and/or ultrasound, with radiologic supervision and interpretation, when performed	Rf magnetic-guide av fistula	1/1/2019	6/30/2020	G2171
G2171	Percutaneous arteriovenous fistula creation (AVF), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, when performed) and fistulogram(s), angiography, enography, and/or ultrasound, with radiologic supervision and interpretation, when performed	AVF use magnetic/art /ven	7/1/2020	N/A	N/A

3. New HCPCS Codes Describing Strain-Encoded Cardiac Magnetic Resonance Imaging (MRI) Effective July 1, 2020

For the July 2020 update, CMS is establishing two new codes to describe the technology associated with strain-encoded cardiac MRI. Specifically, CMS is establishing HCPCS codes C9762 and C9763 to describe the strain imaging and stress imaging associated with strain-encoded cardiac MRI. Table 3 lists the long and short descriptors and ASC PI for both codes. Updated payment rates, effective July 1, 2020, are available in the July 2020 update of ASC Addendum BB at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

Table 3. — New HCPCS Codes Describing Strain-Encoded Cardiac Magnetic Resonance Imaging (MRI) Effective July 1, 2020

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI
C9762	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging	Cardiac MRI seg dys strain	Z2
C9763	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging	Cardiac MRI seg dys stress	Z2

4. New Device Pass-Through Categories

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two (2), but not more than three (3) years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. CMS implemented this policy in the 2008 revised ASC payment system. Therefore, additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the OPPS. Effective July 1, 2020, one new device pass-through category has been created: HCPCS code C1748, as described in Table 4.

Table 4. – New Device Pass-Through Code Effective July 1, 2020

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI
C1748	Endoscope, single-use (i.e. disposable), upper gi, imaging/illumination device (insertable)	Endoscope, single, UGI	J7

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5. Device Offset from Payment:

Section 1833(t)(6)(D)(ii) of the Act requires that, under the OPPS, we deduct from pass-through payments for devices an amount that reflects the portion of the Ambulatory Payment Classification (APC) payment amount. CMS implemented this policy in the 2008 revised ASC payment system.

a. HCPCS code C1748

CMS has determined the device offset amount, or the portion of the OPPS APC payment amount that is associated with the costs of the device category described by HCPCS code C1748, is reflected in APC 5303 (Level 3 Upper Gastrointestinal (GI) Procedures) and APC 5331 (Complex GI Procedures). This device offset amount is also implemented in the ASC setting and represents a deduction for the device portion that is included in the procedure payment rate. The C1748 device should always be billed with one of the following CPT codes: 43260-43265, and 43274-43278.

b. Application of Offset for C1734

On January 1, 2020, CMS determined that a device offset would apply to C1734 because APC 5115 (Level 5 Musculoskeletal Procedures) and APC 5116 (Level 6 Musculoskeletal Procedures) already contain costs associated with the device described by C1734. C1734 should always be billed with CPT codes 27870, 28715, 28725 (which are assigned to APC 5115 for CY 2020) and 28705 (which is assigned to APC 5116 for CY 2020). The device offset is a deduction from OPPS pass-through payments for C1734. After further review, we have determined that the costs associated with C1734 are not already reflected in APCs 5115 or 5116. Therefore, we are not applying an offset to C1734. This determination to not apply the device offset from payment also impacts ASCs and will be retroactive to January 1, 2020. Your MAC will reprocess the impacted ASC claims.

c. Correction to the Device Offset Amount and Procedure Payment Rates for 0548T and 0549T

For CY 2020, in the absence of claims data, we applied a default device offset percentage of 31 percent for CPT codes 0548T and 0549T. Under existing OPPS policy, the associated claims data used for purposes of determining whether or not to apply the default device offset are the associated claims data for either the new HCPCS code or any predecessor code, as described by CPT coding guidance, for the new HCPCS code. Additionally, in limited instances where a new HCPCS code does not have a predecessor code as defined by CPT, but describes a procedure that was previously described by an existing code, we use clinical discretion to identify HCPCS codes that are clinically related or similar to the new HCPCS code, but are not officially recognized as a predecessor code by CPT, and to use the claims data of the clinically related or similar code(s) for purposes of determining whether or not to apply the default device offset to the new HCPCS code. This payment policy is also implemented in the ASC setting.

After further review, we have determined that the device offset percentage for C9746, the predecessor code to CPT code 0548T, which was deleted June 30, 2019, would be a more appropriate, and clinically similar, device offset percentage for CPT codes 0548T and 0549T.

For CY 2020, the ASC device offset percentage for C9746 based on CY 2018 claims data was 69.20 percent. For CPT codes 0548T and 0549T, a device offset percentage of 69.20 percent results in device offset amounts of $5,472.11 for CPT code 0548T and $2,706.54 for CPT code 0549T for CY 2020. These offset amounts reflect the no cost/full credit (FB modifier) amount that is offset from the procedure payment rate when the device used with the procedure is identified as a no cost/full credit device. The device offset amounts when a partial credit (FC modifier) applies to the device identified on the claim is $2736.06 for CPT code 0548T and $1353.27 for CPT code 0549T. This determination to apply the device offset percentage for C9746 to CPT codes 0548T and 0549T is retroactive to January 1, 2020. This determination also changes the ASC procedure payment rates for 0548T and 0549T. The updated payment rates are in the July 2020 update of ASC Addenda at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html. Your MAC will reprocess the impacted ASC claims.

6. HCPCS Codes for Certain Drugs and Biologicals

a. New HCPCS Codes and Code Changes for Certain Drugs and Biologicals Effective July 1, 2020

18 new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available. These new codes are effective July 1, 2020, and are listed in Table 5.

Table 5. — New HCPCS Codes and Code Changes for Certain Drugs and Biologicals Effective July 1, 2020

New HCPCS Code	Old HCPCS Code	CY 2020 Long Descriptor	CY 2020 Short Descriptor	CY 2020 SI
C9059		Injection, meloxicam, 1 mg	Injection, meloxicam	K2
J9358		Injection, fam-trastuzumab deruxtecan-nxki, 1 mg	Inj fam-trastu deru-nxki 1mg	K2
J7204		Injection, factor VIII, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei, per IU	Inj recombin esperoct per iu	K2
J9177		Injection, enfortumab vedotin-ejfv, 0.25 mg	Inj enfort vedo-ejfv 0.25mg	K2
J0742		Injection, imipenem 4 mg, cilastatin 4 mg and relebactam 2 mg	Inj imip 4 cilas 4 releb 2mg	K2
C9061		Injection, teprotumumab-trbw, 10 mg	Injection, teprotumumab-trbw	K2
J1429		Injection, golodirsen, 10 mg	Inj golodirsen 10 mg	K2

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New HCPCS Code	Old HCPCS Code	CY 2020 Long Descriptor	CY 2020 Short Descriptor	CY 2020 SI
C9063		Injection, eptinezumab-jjmr, 1 mg	Injection, eptinezumab-jjmr	K2
C9122		Mometasone furoate sinus implant, 10 micrograms (Sinuva)	Mometasone furoate (Sinuva)	K2
J0896		Injection, luspatercept-aamt, 0.25 mg	Inj luspatercept-aamt 0.25mg	K2
J7169	C9041	Injection, coagulation factor xa (recombinant), inactivated-zhzo (andexxa), 10 mg	Inj andexxa, 10 mg	K2
J0791	C9053	Injection, crizanlizumab-tmca, 5 mg	Inj crizanlizumab-tmca 5mg	K2
J0691	C9054	Injection, lefamulin, 1 mg	Inj lefamulin 1 mg	K2
J0223	C9056	Injection, givosiran, 0.5 mg	Inj givosiran 0.5 mg	K2
J1201	C9057	Injection, cetirizine hydrochloride, 0.5 mg	Inj. cetirizine hcl 0.5mg	K2
Q5120*	C9058	Injection, pegfilgrastim-bmez, biosimilar, (ziextenzo), 0.5 mg	Inj pegfilgrastim-bmez 0.5mg	K2
J1558		Injection, immune globulin (xembify), 100 mg	Inj. xembify, 100 mg	K2
J9246		Injection, melphalan (evomela), 1 mg	Inj., evomela, 1 mg	K2

*Q5120 is being added to the ASC payment system effective 7/1/2020. The HCPCS code creation date is 11/15/2019

b. CY 2020 Drugs and Biologicals with Retroactive ASC PI change for the Period of February 23, 2020, through June 30, 2020

The ASC PI for HCPCS code Q5116 (Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg) for the period of February 23, 2020, through June 30, 2020, will be changed retroactively from ASCPI = “Y5” to ASCPI = “K2.” This drug/biological is reported in Table 6. Q5116 will continue to carry an ASCPI = K2 beginning July 1, 2020.

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Table 6. — CY 2020 Drugs and Biologicals with Retroactive ASC PI change for the Period of February 23, 2020, through June 30, 2020

HCPCS Code	Long Descriptor	Short Descriptor	Old ASC PI	New ASC PI	Effective Date
Q5116	Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg	Inj., trazimera, 10 mg	Y5	K2	02/23/2020

c. CY 2020 Drugs and Biologicals with Retroactive ASC PI change for the Period of March 16, 2020, through June 30, 2020

The ASC PI for HCPCS code Q5113 (Injection, trastuzumab-pkrb, biosimilar, (herzuma), 10 mg) for the period of March 16, 2020, through June 30, 2020, will be changed retroactively from ASCPI = “Y5” to ASCPI = “K2”. This drug/biological is reported in Table 7. Q5113 will continue to carry an ASCPI = K2 beginning July 1, 2020.

Table 7. — CY 2020 Drugs and Biologicals with Retroactive ASC PI change for the Period of March 16, 2020, through June 30, 2020

HCPCS Code	Long Descriptor	Short Descriptor	Old ASC PI	New ASC PI	Effective Date
Q5113	Injection, trastuzumab-pkrb, biosimilar, (herzuma), 10 mg	Inj herzuma 10 mg	Y5	K2	03/16/2020

d. CY 2020 Drugs and Biologicals with Effective Date of February 3, 2020

HCPCS code Q5119 (Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg) will be separately payable in the ASC payment system beginning February 3, 2020, and will have an ASCPI = “K2”. This drug/biological is reported in Table 8. Q5119 will continue to carry an ASCPI = K2 beginning July 1, 2020.

Table 8. — CY 2020 Drugs and Biologicals with Effective Date of February 3, 2020

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI	Effective Date
Q5119	Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg	Inj ruxience, 10 mg	K2	02/03/2020

e. CY 2020 Drugs and Biologicals that Will Be Separately Payable (ASCPI = “K2”) Retroactively Beginning November 15, 2019

HCPCS code C9058 (Injection, pegfilgrastim-bmez, biosimilar, (Ziextenzo) 0.5 mg) became effective and separately payable with an ASCPI = “K2” effective April 1, 2020. It is now retroactively separately payable from November 15, 2019, through March 31, 2020, with an ASCPI = “K2”. This drug/biological is reported in Table 9. C9058 is replaced by Q5120 effective July 1, 2020

Table 9. — CY 2020 Drugs and Biologicals that Will Be Separately Payable (ASCPI = “K2”) Retroactively Beginning November 15, 2019

HCPCS Code	Short Descriptor	ASC PI	Effective Date
C9058	Injection,pegfilgrastim-bmez	K2	11/15/2019

f. Existing HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with a Change from Non-Payable Status (ASCPI = “Y5”) to Vaccine Not Payable in the ASC (ASCPI = “M6”)

The ASC PI for CPT code 90694 (Influenza virus vaccine, quadrivalent (aiiv4), inactivated, adjuvanted, preservative free, 0.5 ml dosage, for intramuscular use) changes from ASCPI = “Y5” to ASCPI = “M6” effective July 1, 2020, as the vaccine described by CPT code 90694 may be covered by Medicare, but is payable outside of the ASC payment system.

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by the corrections in this transmittal may request their MAC adjustment of previously processed claims.

g. Correction for HCPCS Q4206

Per the discussion in the April 2020 quarterly update, CR 11694, (see the related article at https://www.cms.gov/files/document/MM11694.pdf) CMS is adding HCPCS Q4206 (Fluid flow or fluid GF, 1 cc) in this transmittal, retroactively to the ASC PI file, effective October 1, 2019. Q4206 is a packaged service (ASCPI = N1). ASCs are reminded not to bill packaged codes.

7. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

For CY 2020, payment for nonpass-through drugs and biologicals continues to be made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. In addition, in CY 2020, a single payment of ASP + 6 percent continues to be made for the OPPS pass-through drugs and biologicals to provide payment for both the acquisition cost and pharmacy overhead costs of

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these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective July 1, 2020, can be found in the July 2020 update of ASC Addendum BB at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

8. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals with payment rates based on the ASP methodology may have their payment rates corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be accessible on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html. Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request their MAC adjustment of the previously processed claims.

9. New Skin Substitute Products Low Cost Group/High Cost Group Assignment Effective July 1, 2020

The payment for skin substitute products that do not qualify for hospital OPPS pass-through status are packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. The skin substitute products are divided into two groups for packaging purposes: 1. High cost skin substitute products. High cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by CPT codes 15271-15278. 2. Low cost skin substitute products. Low cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278.

All OPPS pass-through skin substitute products (ASCPI = K2) should be billed in combination with one of the skin application procedures described by CPT code 15271-15278. Table 10 lists the skin substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable. Note that ASCs should not separately bill for packaged skin substitutes (ASC PI=N1) since packaged codes are not reportable under the ASC payment system.

Table 10. ─ New Skin Substitute Products Low Cost Group/High Cost Group Assignment Effective July 1, 2020

CY 2020 HCPCS Code	CY 2020 Short Descriptor	CY 2020 SI	Low/High-Cost Skin Substitute
C1849	Skin substitute, synthetic	N1	High

CY 2020 HCPCS Code	CY 2020 Short Descriptor	CY 2020 SI	Low/High-Cost Skin Substitute
Q4227	Amniocore per sq cm	N1	Low
Q4228	Bionextpatch, per sq cm	N1	Low
Q4229	Cogenex amnio memb per sq cm	N1	Low
Q4232	Corplex, per sq cm	N1	Low
Q4234	Xcellerate, per sq cm	N1	Low
Q4235	Amniorepair or altiply sq cm	N1	Low
Q4236	Carepatch per sq cm	N1	Low
Q4237	Cryo-cord, per sq cm	N1	Low
Q4238	Derm-maxx, per sq cm	N1	Low
Q4239	Amnio-maxx or lite per sq cm	N1	Low
Q4247	Amniotext patch, per sq cm	N1	Low
Q4248	Dermacyte Amn mem allo sq cm	N1	Low

ADDITIONAL INFORMATION

The official instruction, CR 11842, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10188cp.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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DOCUMENT HISTORY

Date of Change	Description
July 2, 2020	We revised this article to correct the last sentence in Section 6.e, on page 10. It should have stated, "C9058 is replaced by Q5120 effective July 1, 2020."
June 24, 2020	Initial article released.

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