

C Medicare B CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

April 2018



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Increased ambulance payment reduction for non-emergency basic life support transports to and from dialysis facilities

Provider type affected

This *MLN Matters*® article is intended for providers and suppliers billing Medicare administrative contractors (MACs) for ambulance transport services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10549 provides instructions regarding Section 53108 of the Bipartisan Budget Act of 2018. This section reduces the ambulance payment by 23 percent for non-emergency basic life support (BLS) transports of individuals with end-stage renal disease (ESRD), to and from renal dialysis treatment (at both hospital-based and free-standing renal dialysis treatment facilities). Please make sure your billing staffs are aware of these changes.

Background

Payment for ambulance transports (including items and services furnished in association with such transports) are

based on the ambulance fee schedule (AFS) and include a base rate payment plus a separate payment for mileage. This raised payment reduction for non-emergency BLS transports to and from renal dialysis treatment applies to both the base rate and the mileage reimbursement.

CR 8269, issued May 10, 2013, implemented Section 637 of the American Taxpayer Relief Act of 2012, which, for transports occurring on and after October 1, 2013; required a 10 percent reduction in fee schedule payments for non-emergency (BLS transports of beneficiaries with ESRD); to and from both hospital-based and freestanding renal dialysis treatment facilities, for non-emergent dialysis services. The *MLN Matters*® article associated with this CR is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8269.pdf>.

CR 10549 provides instructions regarding Section 53108 of the Bipartisan Budget Act of 2018, (signed into law February 9, 2018), which requires that, effective October 1, 2018, the reduction of fee schedule payments for

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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Articles included in the *Medicare B Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

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About the Medicare B Connection

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website at <https://medicare.fcso.com>. In some cases, additional unscheduled special issues may be posted.

Who receives the *Connection*

Anyone may view, print, or download the *Connection* from our provider education website(s). Providers who cannot obtain the *Connection* from the internet are required to register with us to receive a complimentary hardcopy.

Distribution of the *Connection* in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the *Connection* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare provider enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example,



“Mental Health” would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

- The section pertaining to **Electronic Data Interchange (EDI)** submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.
- In addition to the above, other sections include:
- **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

The *Medicare B Connection* represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our “*time limit*” calculators on our *Appeals of claim decisions* page. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Medicare Part B advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning

March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44>.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html>.



ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (waiver of liability statement on file).

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the applicable contact section located at the end of this publication for the address in which to send written appeals requests.

July quarterly update to correct coding initiative edits

Provider type affected

This *MLN Matters*® article is intended for physicians, providers and suppliers billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10593 includes the normal update to the National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) edits. This update applies to Chapter 23, Section 20.9 of the *Medicare Claims Processing Manual*. Please make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. Version 24.2 will include all previous versions and updates from January 1, 1996, to the present. In the past, NCCI was organized in two tables: Column one/column two correct coding edits and mutually exclusive code (MEC) edits. To simplify the use of NCCI edit files (two tables), April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the outpatient code editor (OCE). It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits.

CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file on each website. You should note that **the edits previously contained in the mutually exclusive edit file are NOT being deleted but are being moved to**

the column one/column two correct coding edit file.

Please refer to the CMS NCCI web page for additional information at <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>.



The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology* manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

Additional information

The official instruction, CR 10593, issued to your MAC regarding this change is available at [https://www.cms.gov/Regulations-and-Guidance/Guidance/](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4022CP.pdf)

[Transmittals/2018Downloads/R4022CP.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4022CP.pdf). If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

Date of change	Description
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Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.



Ambulance

Manual update regarding ambulance transportation for a SNF resident in a stay not covered by Part A

Provider type affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNF), ambulance providers and suppliers providing ambulance services to patients and billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries who are not in a covered Part A stay.



Provider action needed

Change request (CR) 10550 provides clarification on coverage of an ambulance transport for a SNF resident in a stay not covered by Part A, who has Part B benefits, to the nearest supplier of medically necessary services not available at the SNF, including the return trip. These clarifications relate to Chapter 10 of the *Medicare Benefit Policy Manual*, and Chapter 15, of the *Medicare Claims Processing Manual*. The revised manual sections are attachments to CR 10550. Make sure your billing staffs are aware of these clarifications.

Background

In the June 17, 1997, ambulance proposed rule (62 FR 32720), the Centers for Medicare & Medicaid Services (CMS) proposed a provision under Part B that permits ambulance transportation from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is an inpatient, including the return trip. CMS finalized this proposal in the January 25, 1999, final rule (64 FR 3648) at 42 CFR 410.40(e)(3).

CMS is revising the *Medicare Benefit Policy Manual* and *Medicare Claims Processing Manual* to clarify that a medically necessary ambulance transport from an SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident (including the return trip) may be covered under Part B. This applies to beneficiaries who are in an SNF stay not covered by Part A, but who has Part B benefits.

For example, this includes ambulance transport of such residents from the SNF (modifier N) to the nearest diagnostic or therapeutic site, other than a physician's

office or hospital, such as an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, or wound care center, as reported with ambulance modifier D. For SNF residents receiving Part A benefits, this type of ambulance service is subject to SNF consolidated billing.

Additional information

The official instruction, CR 10550, issued to your MAC regarding this change, consists of two transmittals. The first updated the *Medicare Claims Processing Manual* and it is available at

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4021CP.pdf>. The second transmittal updates the *Medicare Benefit Policy Manual* and it is at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R243BP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

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REDUCTION

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BLS transports to and from renal dialysis treatments be increased to 23 percent.

Non-emergency BLS ground transports are identified by Healthcare Common Procedure Coding System (HCPCS) code A0428 (Ambulance service, basic life support, non-emergency transport, (BLS)). Ambulance transports to and from renal dialysis treatment are further identified by origin/destination modifier codes “G” (hospital-based ESRD) and “J” (freestanding ESRD facility), in either the origin or destination position of an ambulance modifier.

Specific details

- Effective for claims with dates of service on and after October 1, 2018, payment for non-emergency BLS transports to and from renal dialysis treatment facilities will be reduced by 23 percent. The reduced rate will be calculated after the normal payment rate (including any applicable add-on payments) is calculated, and will be applied to the base rate for non-emergency BLS transports (identified by HCPCS code A0428 when billed with the indicated modifier codes) and the associated, separate mileage payment (identified by HCPCS code A0425).
- Payment for emergency transports and non-emergency BLS transports to other destinations (rural and urban) will remain unchanged. The AFS will also remain unchanged.
- For ambulance services, suppliers and hospital-based ambulance providers must report an accurate origin and destination modifier for each ambulance trip provided. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of “X”, represents an origin code or a destination code. The pair of alpha codes creates a modifier. The first position alpha code equals origin; the second position alpha code equals destination.
- The reduction will be applied on claim lines containing HCPCS code A0428 with modifier code “G” or “J”, in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code and HCPCS code A0425.
- MACs will keep in place all existing edits and logic (implemented previously via CMS CR 8269) that

currently apply to the reduced AFS payment rates; however, effective for claims with dates of service on or after October 1, 2018, will increase the reduction from 10 percent to 23 percent. Additionally, they will continue to use the claim adjustment reason code, group code and Medicare summary notice messages that are currently used for the reduced AFS payment methodology

Note: This 23-percent reduction applies to beneficiaries with ESRD that are receiving a non-emergency BLS transport to and from renal dialysis treatment. While it is possible that a beneficiary who is not diagnosed with ESRD will require routine transport to and from renal dialysis treatment, it is highly unlikely. However, MACs have the discretion to override or reverse the reduction on appeal if they deem it appropriate based on supporting documentation.

Additional information

The official instruction, CR 10549, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4017CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

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Drugs & Biologicals

July 2018 update of drug and biological code changes

Provider type affected

This *MLN Matters*[®] article is intended for physicians, providers and suppliers billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10624 informs MACs of updated drug/biological HCPCS codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes four new HCPCS codes: Q9991, Q9992, Q9993 and Q9995. Please make sure your billing staffs are aware of these updates.

Background

The July 2018 HCPCS file includes four new HCPCS codes, which are payable by Medicare, effective for claims with dates of service on or after July 1, 2018. These codes are:

- **Q9991**
 - Short description: Buprenorph xr 100 mg or less
 - Long description: Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
 - Type of service (TOS) code: 1
 - Medicare physician fee schedule database (MPFSDB) status indicator: E
- **Q9992**
 - Short description: Buprenorphine xr over 100 mg
 - Long description: Injection, buprenorphine extended-release (sublocade), greater than 100 mg
 - TOS code: 1
 - MPFSDB status indicator: E
- **Q9993**
 - Short description: Inj., triamcinolone ext rel
 - Long description: Injection, triamcinolone acetate, preservative-free, extended release, microsphere formulation, 1 mg

- TOS code: 1,P
- MPFSDB status indicator: E
- **Q9995**
 - Short description: Inj. emicizumab-kxwh, 0.5 mg
 - Long description: Injection, emicizumab-kxwh, 0.5 mg
 - TOS code: 1
 - MPFSDB status indicator: E

Additional information

The official instruction, CR 10624, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4025CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

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New Medicare cards

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires the Centers for Medicare & Medicaid Services (CMS) to remove Social Security numbers (SSNs) from all Medicare cards by April 2019. A new Medicare beneficiary identifier (MBI) will replace the SSN-based health insurance claim number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

The new Medicare cards will be mailed through April 2019. Resources are available to prepare you for this change at https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp.



Laboratory/Pathology

Proper coding for specimen validity testing billed in combination with drug testing

Provider type affected

This *MLN Matters*® article is intended for laboratories and other providers billing Medicare administrative contractors (MACs) for urine drug test services provided to Medicare beneficiaries.

Provider action needed

This *MLN Matters*® special edition article reminds laboratories and other providers about how to properly bill for specimen validity testing done in conjunction with drug testing. This article contains no policy changes, but serves as a reminder to laboratories and providers of current Medicare requirements. Please make sure your billing staffs are aware of these instructions.

Background

The Centers for Medicare & Medicaid Services (CMS) is issuing SE18001 to remind laboratories and other providers about the correct coding and instructions for billing specimen validity testing when done as a part of drug testing.

Section 1862(a)(1)(A) of the Social Security Act provides that Medicare payment may not be made for services that are not reasonable and necessary. Clinical laboratory services must be ordered and used by the physician who is treating the beneficiary as described in 42 CFR 410.32(a), or by a qualified nonphysician practitioner, as described in 42 CFR 4310.32(a)(3).

Current coding for testing for drugs of abuse relies on a structure of “screening” (known as “presumptive” testing) and “quantitative” or “definitive” testing that identifies the specific drug and quantity in the patient.

Beginning January 1, 2017, presumptive drug testing may be reported with CPT® codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

The descriptors for presumptive drug testing codes are:

- **80305:** Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
- **80306:** Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) read by instrument-assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
- **80307:** Drug tests(s), presumptive, any number of

drug classes, qualitative, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.

As mentioned in the *National Correct Coding Initiative Policy Manual*, Chapter 10, Section E, beginning January 1, 2016, definitive drug testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.

The descriptors for definitive drug testing codes are:

- **G0480:** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed
- **G0481:** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed
- **G0482:** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but

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TESTING

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not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed

- **G0483:** Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed

In addition, definitive drug testing code G0659 was created to recognize those laboratories that are performing a less sophisticated version of these tests than is usually performed in drug testing laboratories:

- **G0659:** Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized

internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes

The work performed in this test approximates the work performed in CPT® code 80307.

Providers performing validity testing on urine specimens utilized for drug testing *shall* not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.

Additional information

The *National Correct Coding Initiative Policy Manual* is available in the *Downloads* section of <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>.

The Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) recently completed a report that illustrated improper payments for specimen validity tests as part of urine drug testing. To review that report, visit <https://oig.hhs.gov/oas/reports/region9/91602034.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

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Correct your claims on the 'SPOT'

The SPOT offers registered users the time-saving advantage of not only viewing claim data online but also the option of correcting clerical errors on their eligible Part B claims quickly, easily, and securely – online.



CMS releases the July update to new waived tests

Provider type affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10586 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so they can accurately process claims. Make sure your billing staffs are aware of these CLIA-related changes.

Background

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The *Current Procedural Terminology* (CPT®) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to [CR 10586](#) (that is, CPT® codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT® code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- 80305QW, December 7, 2017, Jant Pharmacal Corporation Accutest Value+Multi-Drug Urine Test Cup
- 87502QW, December 19, 2017, Cepheid Gene Xpert Xpress System (Xpert Flu Xpress)
- 87880QW, December 21, 2017, Quidel Sofia 2 (Sofia StrepA+FIA){from throat swab only}

- 82044QW, 82570QW, January 11, 2018, Medline Industries, Inc., Medline 120 Mini Analyzer Test System (Medline Industries, Inc. Medline Urinalysis Reagent Strips)
- 80061QW, 82465QW, 83718QW, 84478QW, January 19, 2018, ACON Laboratories Inc., Mission Cholesterol Pro Monitoring System (Mission Cholesterol Pro Test Cartridges)
- G0433QW, January 30, 2018, bioLytical Laboratories, INSTI HIV-1/HIV-2 Antibody Test {Fingerstick whole blood}

The attachment to CR 10586 contains the test name, manufacturer, and use for each of the above listed CPT® codes. You should be aware that MACs will not search their files to either retract payment or retroactively pay claims. However, they should adjust claims that you bring to their attention.

Additional information

The official instruction, CR 10586, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4018CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

Date of change	Description
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MLN Matters® Number: MM10586
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 Related Change Request (CR) Number: 10586
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ADR status search is here

Users of the Secure Provider Online Tool (SPOT) have a more focused and detailed look at pending and received additional development requests (ADR) with the launch of the new medical review *ADR status lookup functionality*. The new lookup function is located under the Claims navigation at the top of every page, and lets users search for the review status of claims for which an ADR letter was sent related to medical review. **Note:** This function is for medical review ADRs only, not all ADRs.



Preventive Services

Change in type of service for CPT® code 77067

Provider type affected

This *MLN Matters*® article is intended for physicians, providers and suppliers billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10607 updates the type of service (TOS) code for *Current Procedural Terminology* (CPT®) code 77067. CR 10607 corrects the TOS indicator assigned to CPT® code 77067 – screening mammography. Effective for claims with dates of service on or after January 1, 2017, the TOS indicator is updated to reflect “1” instead of “4” to allow for proper claim submission and adjudication. Make sure your billing staffs are aware of this change.

Background

The Centers for Medicare & Medicaid Services (CMS) issued CR 10181 November 21, 2017. A corresponding *MLN Matters*® article is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10181.pdf>.

In part, CR 10181 instructed the Medicare claim processing system maintainers and MACs to implement CPT® code 77067 in place of the Healthcare Common Procedure Coding System (HCPCS) screening mammography code G0202, effective for claims with dates of service on or after January 1, 2018.

CMS instructed the MACs to apply the same payment methodologies and editing as applicable for CPT® code 77067 as they did for G0202. As part of the instruction to apply the same editing, the TOS coding for the 77067 should have remained, as it was for G0202, with a “1” (Medical Care) indicator. Correcting the TOS code for 77067 allows the screening mammography claims to be billed without referring physician information on the claim, which is consistent with Medicare’s coverage policy for screening mammograms. See *Chapter 18*, Section 20 of the *Medicare Claims Processing Manual* for more information.

Note: MACs will automatically reprocess previously adjudicated screening mammography claims received with CPT® 77067 with a TOS code of “4” with dates of service on and after January 1, 2018, and through July 2, 2018, when the claim was denied because there was no referring provider information. MACs will reprocess screening mammography claims with dates of service between January 1, 2018, and July 2, 2018, which cannot be automatically reprocessed only if brought to their attention.

Additional information

The official instruction, CR 10607, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2054OTN.pdf>.

The *Medicare Claims Processing Manual*, Chapter 18, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

Date of change	Description
April 13, 2018	Initial article released.

MLN Matters® Number: MM10607
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 Related Change Request (CR) Number: 10607
 Effective Date: January 1, 2017
 Implementation Date: July 2, 2018

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Alcohol misuse screening and counseling

About 38 million adults in the United States drink too much. Only one in six adults have talked to a health professional. Alcohol screening and brief counseling has been proven to work and talking to your patient is the first step!

All Medicare beneficiaries are eligible for alcohol screening. Medicare beneficiaries who screen positive are eligible for counseling if both of the following are met:

- Competent and alert at the time counseling is provided.
- Counseling is furnished by qualified primary care physician or other primary care practitioners in a primary care setting.

Learn more about this positive preventive benefit on the [Centers for Medicare & Medicaid Services \(CMS\) MLN Educational Tool, Medicare Preventive Services](#).

Therapy Services

Supervised exercise therapy for symptomatic peripheral artery disease

Note: The article was revised April 5, 2018, to reflect a revised change request (CR). The Medicare administrative contractor (MAC) implementation date, CR release date, transmittal numbers, and the web addresses of the transmittals were revised. In addition, the article and CR were revised to delete place of service (POS) codes 19 and 22 as acceptable POS for CPT® 93668. The article was also revised April 11, 2018, to clarify that the supervised exercise therapy (SET) program must be provided in a physician's office (POS 11). All other information remains the same.

[March 2018 Medicare B Connection, pages 15-17.](#)

Note: Editorial corrections made May 23, 2018, to second bullet and transmittal numbers/links.

Provider type affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers billing MACs for services provided to Medicare beneficiaries.

Provider action needed

CR 10295 informs MACs that effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) to cover SET for beneficiaries with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD). Make sure your billing staffs are aware of these changes.

Background

SET involves the use of intermittent walking exercise, which alternates periods of walking to moderate-to-maximum claudication, with rest. SET has been recommended as the initial treatment for patients suffering from IC, the most common symptom experienced by people with PAD.

Despite years of high-quality research illustrating the effectiveness of SET, more invasive treatment options (such as, endovascular revascularization) have continued to increase. This has been partly attributed to patients having limited access to SET programs. There is currently no NCD in effect.

CMS issued the NCD to cover SET for beneficiaries with IC for the treatment of symptomatic PAD. Up to 36 sessions over a 12-week period are covered if all of the following components of a SET program are met:

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Be conducted in a physician's office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD

- Be under the direct supervision of a physician (as defined in Section 1861(r)(1)) of the Social Security Act (the Act), physician assistant, or nurse practitioner/clinical nurse specialist (as identified in Section 1861(aa)(5) of the Act)) who must be trained in both basic and advanced life support techniques.

Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments.

MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of time. MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the services that documentation is on file verifying that further treatment beyond the 36 sessions of SET over a 12-week period meets the requirements of the medical policy. SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary attending physician.

Coding requirements for SET

Providers should use *Current Procedural Terminology* (CPT®) 93668 (under peripheral arterial disease rehabilitation) to bill for these services with appropriate International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) code as follows:

- I70.211 – right leg
- I70.212 – left leg
- I70.213 – bilateral legs
- I70.218 – other extremity
- I70.311 – right leg
- I70.312 – left leg
- I70.313 – bilateral legs
- I70.318 – other extremity
- I70.611 – right leg
- I70.612 – left leg
- I70.613 – bilateral legs
- I70.618 – other extremity
- I70.711 – right leg
- I70.712 – left leg
- I70.713 – bilateral legs

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PAD

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- I70.718 – other extremity

Medicare will deny claim line items for SET services when they do not contain one of the above ICD-10 codes using the following messages:

- Claim adjustment reason code (CARC) 167 – This (these) diagnosis (es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <https://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

MACs will accept claims for CPT® 93668 only when services are provided in POS code 11. MACs will deny claims for SET if services are not provided in POS 11 using the following remittance messages:

- CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note:** Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- RARC N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <https://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Institutional claims for SET must be submitted on type of bills (TOB) 13x or 85x. MACs will deny line items on institutional claims that are not submitted on TOB 13x or 85x using the following messages:

- CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note:** Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- RARC N386: “This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <https://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact

the contractor to request a copy of the NCD.

- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Medicare will pay claims for SET services containing CPT® code 93668 on types of bill (TOBs) 13x under OPSS and 85x on reasonable cost, except it will pay claims for SET services containing CPT® 93668 with revenue codes 096x, 097x, or 098x when billed on TOB 85x method II critical access hospitals (CAHs) based on 115 permission of the lesser of the fee schedule amount or the submitted charge.

Medicare will reject claims with CPT® 93668 which exceed 36 sessions within 84 days from the date of the first session when the KX modifier is not included on the claim line OR any SET session provided after 84 days from the date of the first session and the KX modifier is not included on the claim and use the following messages:

- CARC 96: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N640: Exceeds number/frequency approved/ allowed within time period.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

MACs will deny/reject claim lines for SET exceeding 73 sessions using the following codes:

- CARC 119: Benefit maximum for this time period or occurrence has been reached.
- RARC N386: “This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

Medicare’s common working file (CWF) will display remaining SET sessions on all CWF provider query screens (HIQA, HIQH, ELGH, ELGA, and HUQA). The multi-carrier system desktop tool will also display remaining SET sessions in a format equivalent to the CWF HIMR screen(s).

See **PAD**, page 15

General Coverage

Claim processing actions to implement certain provisions of the Bipartisan Budget Act of 2018

Provider type affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 10531 provides direction to MACs to reprocess claims related to several provisions of the Bipartisan Budget Act of 2018, referred to as Medicare extenders. Specifically, the CR provides guidance to MACs regarding Medicare fee-for-service (FFS) claim reprocessing requirements and timeframes. Make sure your billing staffs are aware of these changes.

Background

On February 9, 2018, Congress passed the Bipartisan Budget Act of 2018 which contains a number of provisions

that extend certain Medicare FFS policies, including ambulance add-on payment provisions, the work geographic practice cost index (GPCI) floor, and the three percent home health (HH) rural add-on payment. In addition, the Act permanently repeals the outpatient therapy caps beginning January 1, 2018, while retaining the requirement to submit the KX modifier for services in excess of the prior cap amounts. Due to the retroactive effective dates of these provisions, your MAC will reprocess various Medicare FFS claims impacted by this legislation.

Section 421(a) of the Medicare Modernization Act (MMA), as amended by Section 50208 of the Social Security Act, provides an increase of three percent of the payment amount otherwise made under Section 1895 of the Social Security Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2019. The statute waives

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Additional information

The official instruction, CR 10295, was issued to your MAC via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4016CP.pdf>. The second updates the *NCD Manual* and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R206NCD.pdf>. If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

Date of change	Description
April 11, 2018	The article was revised to clarify that the SET program must be provided in a physician's office (POS code 11). All other information remains the same.

Date of change	Description
April 5, 2018	The article was revised to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the web addresses of the transmittals were revised. In addition, the article and CR were revised to delete POS codes 19 and 22 as acceptable places of service for CPT® 93668. All other information remains the same.
March 5, 2018	The article was revised to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the Web addresses of the transmittals were revised. All other information remains the same.
February 6, 2018	Initial article released.

MLN Matters® Number: MM10295
 Related CR Release Date: April 3, 2018
 Related CR Transmittal Number: R206NCD and R4016CP
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BBA

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budget neutrality related to this provision.

As a result of the work GPCI floor changes, certain federally qualified health center (FQHC) geographic adjustment factors (GAFs) will change, which may result in a change to some FQHC payments. For inpatient prospective payment system (IPPS) hospitals, temporary changes to the low-volume hospital payment adjustment and the Medicare-dependent hospital (MDH) program have been extended. In addition, for the long-term care hospital prospective payment (LTCH PPS), the blended payment rate for site neutral payment rate cases is extended for certain LTCH hospital discharges. Separate instructions addressing these payment updates are forthcoming.

On January 25, 2018, the Centers for Medicare & Medicaid Services (CMS) instructed MACs to release for processing held therapy claims with the KX modifier with dates of receipt January 1- 10, 2018. CMS also instructed the MACs to institute a “rolling hold” for all new therapy claims with the KX modifier. On February 12, 2018, CMS provided direction regarding new Medicare physician fee schedule (MPFS) files and abstract files due to the extension of the work GPCI floor, as well as a revised 2018 ambulance fee schedule (AFS) file. CMS also instructed the MACs to ensure legislative effective indicators were set correctly in Medicare systems to apply therapy policies. Given that legislation has been enacted, CMS is instructing the MACs to reprocess effected claims that were processed using the previous MPFS files.

As stipulated in Section 421(a) of the MMA, the three percent rural add-on is applied to the national, standardized episode rate, national per-visit payment rates, low-utilization payment adjustment (LUPA) add-on payments, and the non-routine supplies (NRS) conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2019. Refer to Tables 1 through 4 of the attachment to CR 10531 for the 2018 rural payment rates. CR 10531 is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2047OTN.pdf>.

Section 1848(e)(1)(E) of the Social Security Act stipulates that after calculating the work geographic index for purposes of MPFS payment for services furnished, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00. This provision expired on December 31, 2017, and the locality-specific anesthesia conversion factors for 2018 were calculated without this work geographic index floor of 1.00 in place.

Section 50201 of the Bipartisan Budget Act of 2018 restored the work geographic index floor of 1.00 and retroactively dated this restoration to January 1, 2018. In accordance with the law, CMS has updated the locality-specific anesthesia conversion factors for 2018 to include the work geographic index floor of 1.00. These updated

locality-specific anesthesia conversion factors also have a retroactive effective date of January 1, 2018.

CR 10531 reminds the MACs to be aware that Section 1848(b)(4) of the Social Security Act limits MPFS payment for the technical portion of most imaging procedures to the amount paid under the outpatient prospective payment system (OPPS) system. This policy applies to the technical component (and technical portion of global payment) of imaging services, including X-ray, ultrasound, nuclear medicine, MRI, CT, and fluoroscopy services. The MPFS payment rates for some of these services does not reflect the most recent updates to the OPPS rates that were updated in December of 2017. CMS corrected these rates in new MPFS files and informed the MACs of the corrections February 12, 2018. These MPFS files also contain the updates for the GPCI. This correction is unrelated to the passage of this Act, but CMS is taking the opportunity to address this issue now since new MPFS files are required as a result of the Act.

The instructions to the MACs to reprocess claims contain the following specifics:

- The MACs will reprocess therapy claims with the KX modifier containing dates of service in 2018, which were denied prior to the implementation of the updated legislative effective dates issued January 25, 2018.
Note: For institutional claims, these claims will include revenue codes 042x, 043x, or 044x and modifiers GN, GO, or GP.
- The MACs will reprocess therapy claims with the KX modifier which were denied due to an invalid date provided by CMS February 12, 2018.
- The MACs will reprocess 2018 therapy claims which cannot be automatically reprocessed only if you bring such claims to the attention of your MAC.
- The MACs reprocess MPFS claims for localities and states impacted by the work GPCI floor fee increase for dates of service in 2018. Please refer to the chart in Attachment A - Localities and states impacted by the work GPCI floor – 2018 – in CR 10531.
- The MACs will reprocess 2018 MPFS claims for localities and states impacted by the work GPCI floor fee increase for dates of service in 2018 which cannot be automatically reprocessed only if you bring such claims to your MAC’s attention. Please refer to the chart in Attachment A - Localities and states impacted by the work GPCI floor – 2018.
- The MACs will reprocess ground AFS claims using the revised 2018 AFS file for dates of service in 2018.
- The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC’s attention.
- MACs will reprocess home health claims with the following criteria:
 - Type of bill 32x
 - Claim “Through” dates on or after January 1, 2018
 - Value code 61 amounts in the range 999xx

See BBA, page 17

SNF advance beneficiary notice of non-coverage

Provider type affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs) billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article informs you about change request (CR) 10567, which advises you that the Centers for Medicare & Medicaid Services (CMS) has revised the skilled nursing facility notice of non-coverage (SNF ABN), Form CMS-10055. With this revision, CMS is discontinuing the five SNF denial letters (namely, the Intermediary Determination of Noncoverage, the UR Committee Determination of Admission, the UR Committee Determination on Continued Stay, the SNF Determination on Admission and the SNF Determination on Continued Stay), and the Notice of Exclusion from Medicare Benefits (NEMB-SNF), Form CMS-20014. Please ensure that your billing staffs are aware of these changes.

Please note that the Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123 is not being discontinued with this revised SNF ABN. More information on the NOMNC is available at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.html>.

Background

The authorization for these requirements are Section 1879 of the Social Security Act and 42 Code of Federal Regulations (CFR) 411.404(b) and (c), which specify written notice requirements. These requirements are fulfilled by the SNF ABN.

In order for SNFs to transfer liability to an original Medicare beneficiary for items or services paid under Medicare Part A (SNF prospective payment system (PPS)), the SNF must issue a

SNF ABN for:

- An item or service that is usually paid for by Medicare, See **SNF**, page 18

BBA

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- Receipt dates prior to the installation of the revised home health Pricer, which reflects the extension of the 3 percent rural add-on for 2018.
- MACs will automatically reprocess claims impacted by the OPPTS cap for dates of service in 2018. The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC's attention.
- The MACs will automatically reprocess anesthesia claims for localities and states impacted by the work GPCI floor fee increase for dates of service in 2018. Please refer to the chart in Attachment A - Localities and states Impacted by the work GPCI floor – 2018. The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC's attention.
- MACs shall ensure all reprocessing actions have been initiated within six months of the issuance of CR 10531:
 - For therapy and MPFS adjustments
 - For ground ambulance service claims with a date of service on or after 1/1/2018
 - For OPPTS adjustments
 - For anesthesia adjustments
- MACs shall ensure all reprocessing actions have been initiated within six months of the implementation date of the Pricer for HH rural add-on adjustments.

Additional information

The official instruction, CR 10531, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2051OTN.pdf>.

www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2051OTN.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

Date of change	Description
April 5, 2018	The article was revised to reflect a revised CR 10531, which was revised to include page two of Attachment B - Rural Add on Rate Tables. In the article, the CR release date, transmittal number, and the web address for CR 10531 are revised. All other information remains the same.
April 6, 2018	Initial article released.

MLN Matters® Number: MM10531 *Revised*
 Related CR Release Date: April 4, 2018
 Related CR Transmittal Number: R2051OTN
 Related Change Request (CR) Number: 10531
 Effective Date: January 1, 2018
 Implementation Date: April 2, 2018; date to begin reprocessing claims

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but may not be paid for in this particular instance because it is not medically reasonable and necessary, or

- Custodial care.

Attached to CR 10567 is a revised Chapter 30 of the *Medicare Claims Processing Manual*. This revised manual chapter provides details on SNF ABN standards and also provides information about:

- Situations in which a SNF ABN should be given
- Situations in which a SNF ABN Is not needed to transfer financial liability to the beneficiary
- SNF ABN specific delivery issues
- Special rules for SNF ABNs
- Establishing when beneficiary is on Notice of Non-coverage

Note: Further details are available at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN-.html>. You may download the revised Form CMS-10055 in the *Downloads* section of that web page.

SNFs will continue to use the advance beneficiary notice of non-coverage (ABN, Form CMS-R-131) for items or services that Medicare may be deny under Medicare Part B.

Please note that SNFs may start to implement this new notice any time up to the implementation date of CR 10567. Upon the CR 10567 implementation April 30, 2018, the use of the new notice is mandatory.

The revised notice incorporates suggestions for changes made by users of the ABN and by beneficiary advocates based on experience with the current form, refinements made to similar liability notices through consumer testing and other means, as well as related Medicare policy changes and clarifications.

Additional information

The official instruction, CR 10567, issued to your



MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4011CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

Date of change	Description
March 30, 2018	Initial article released.

MLN Matters® Number: MM10567
 Related CR Release Date: March 30, 2018
 Related CR Transmittal Number: R4011CP
 Related Change Request (CR) Number: 10567
 Effective Date: April 30, 2018
 Implementation Date: April 30, 2018

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Modifications to the implementation of the paperwork segment of the esMD system

Note: This article was revised April 4, 2018, to reflect a revised change request (CR) issued April 3. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same. This information was previously published in the *March 2018 Medicare B Connection*, page 22.

Provider type affected

This *MLN Matters*[®] article is intended for physicians, suppliers, and providers submitting electronic medical documentation to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 10397 updates the business requirements to enable MACs to receive unsolicited documentation (also known as paperwork (PWK)) via the electronic submission of medical documentation (esMD) system. CR 10397 is for esMD purposes only. Please make sure your billing staffs are aware of these updates.

Background

CR 10397 also contains attachments that include cover sheets that must be used for electronic, fax, or mail submissions of documentation. There are three cover sheets, one each for Part A and Part B providers, as well as one for durable medical equipment (DME) suppliers. In addition, there are two companion guides attached to CR 10397, one for institutional claims and one for professional claims. A link to CR 10397 is available in the *Additional information* section of this article.

With CR 10397, MACs will modify PWK, also known as unsolicited documentation procedures to include electronic submission(s) via esMD. Also, Medicare systems will accept PWK 02 values “EL” and “FT” for those MACs in a CMS-approved esMD system. This mechanism will suppress initial auto letter generation, if applicable, when PWK 02 is “EL” or “FT,” and is present at any level of the claim or line.

Providers will receive communication from MACs via companion documents for 5010 X12 837 to include:

- The value “EL” (electronic) in PWK 02 to represent an esMD submission for sending the documentation using X12 Standards (6020 X12 275)
- The value “FT” (file transfer) in PWK 02 to represent an esMD submission for sending the documentation in PDF format using XDR specifications.

MACs will allow seven calendar “waiting days” (from the date of receipt) for additional information to be submitted when the PWK 02 value is “EL” or “FT.”

MACs will use RC client to reject the PWK data submissions as administrative error(s) when the received cover sheet (via esMD) is incomplete or incorrectly filled out as applicable to current edits. Providers can expect to see new generic reason statements introduced to convey these errors as follows (Codes for these statements will be finalized and sent along with the RC implementation guide):

- The date(s) of service on the cover sheet received is missing or invalid.
- The NPI on the cover sheet received is missing or invalid.
- The state where services were provided is missing or invalid on the cover sheet received.
- The Medicare ID on the cover sheet received is missing or invalid.
- The billed amount on the cover sheet received is missing or invalid.
- The contact phone number on the cover sheet received is missing or invalid.
- The beneficiary name on the cover sheet received is missing or invalid.
- The claim number on the cover sheet received is missing or invalid.
- The attachment control number (CAN) on the cover sheet is missing or invalid.

Once again, examples of the cover sheet are included as an attachment to CR 10397.

Additional information

The official instruction, CR 10397, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2050OTN.pdf>.

The X12 837 companion guides are available at <https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/CompanionGuides.html>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

Date of change	Description
April 3, 2018	The article was revised to reflect a revised CR. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.
February 16, 2018	Initial article released.

MLN Matters[®] Number: MM10397 *Revised*
 Related CR Release Date: April 3, 2018
 Related CR Transmittal Number: R2050OTN
 Related Change Request (CR) Number: 10397
 Effective Date: July 1, 2018
 Implementation Date: July 2, 2018

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Processing Issues

Part B claims billed with radiopharmaceutical codes denied in error

Issue

First Coast Service Options Inc. (First Coast) has identified Part B radiopharmaceutical claims processed March 27 through March 28, 2018, were denied in error.

Resolution

Issue resolved and claims denied in error will be adjusted.

Status/date resolved

This error was corrected on March 29, 2018. Claims processed on or after March 29, 2018, were adjudicated correctly.

Provider action

Providers whose claims were incorrectly denied due to this error do not need to take any action. First- Coast will perform adjustments to correct the error on all the affected claims. We apologize for any inconvenience this may have caused.

Current processing issues

Here is a link to a table of [current processing issues](#) for both Part A and Part B.

General Information

Information from DME MACs about ordering and providing DMEPOS to your patients

As part of collaboration between all of the A/B and durable medical equipment (DME) Medicare administrative contractors (MACs), First Coast Service Options (First Coast) would like to share information with you regarding ordering and providing durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to your patients. The four DME MACs, with feedback from the A/B MACs, created an article that outlines coverage

criteria and documentation requirements for ordering and providing DMEPOS. This article can be located on the website for CGS Administrators. CGS is the DME MAC for Jurisdiction C (JC) which includes our Jurisdiction N (JN) for Florida, Puerto Rico, and the U.S. Virgin Islands. For more information, please review the article [Physicians! Your medical records play a vital role in ordering and providing DMEPOS to your patients!](#)

Medicare fee-for-service response to 2017 California wildfires

Provider type affected

This *MLN Matters*[®] special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries, who were affected by the 2017 wildfires in the state of California.

Provider information available

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of the 2017 wildfires, a major disaster exists in the state of California.

On October 15, 2017, Acting Secretary Hargan of the Department of Health & Human Services declared that a public health emergency exists in the state of California retroactive to October 8, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On October 17, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the state of California retroactive to October 8, 2017 for those people

who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 waiver by following the instructions available at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf>.

Note: The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired January 5, 2018.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed MACs as follows:

Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of California retroactive to October 8, 2017, for the duration of the emergency. In accordance with CR 6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which

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Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

The most current information can be found at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html>.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the State of California. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable **without** any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency.
- Another file addresses policies and procedures that are applicable **only with** approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved individual 1135 waivers requested by providers for California.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

- Q&As applicable **without any Section 1135** or other formal waiver are available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf.
- Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf>.

Waiver for California

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following waiver in the affected areas of California. Individual facilities do not need to apply for the following approved waiver.

Skilled nursing facilities

- 1812(f): This waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility stay provides temporary emergency coverage of skilled nursing facility (SNF) services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).
- In addition, the waiver provides temporary emergency

coverage of SNF services that are not post-hospital SNF services under the authority in §1812(f) of the Social Security Act (the Act), for those people who are evacuated, transferred, or otherwise dislocated as a result of the effects in the state of California, in October 2017. In addition, this waiver provides authority under §1812(f) of the Act to provide coverage for extended care services which will not require a new spell of illness in order to renew provision of services by a SNF. These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under §1135 of the Act in connection with the effects of the wildfires in the State of California in October 2017. Accordingly, both the effective date and expiration date for these temporary emergency policies are the same as those specified pursuant to the §1135 waivers. Further, unlike the policies authorized directly under the §1135 waiver authority itself, the two policies described above would not be limited to beneficiaries who have been relocated within areas that have been designated as emergency areas. Instead, the policies would apply to all beneficiaries who were evacuated from an emergency area as a result of the effects of the wildfires in California in October 2017, regardless of where the “host” SNF providing post-disaster care is located.

Administrative relief

Appeal administrative relief for areas affected by California wildfires

If you were affected by the California wildfires and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your MAC.

Requesting an 1135 waiver

Information for requesting an 1135 waiver can be found at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf>.

More information is available in the 1135 waiver letter, which is posted in the *Downloads* section at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html>.

Medicare quality reporting and value-based purchasing programs

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to acute care hospitals, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, long-term care hospitals, renal dialysis facilities, and ambulatory surgical centers located in areas affected by the devastating impacts of the northern California wildfires since October 8, 2017, in and around counties in northern California. For complete details of these exceptions, see the document posted at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Memo-Requirements-Facilities-CA-Wildfires.pdf>.

See 2017, page 22

Medicare fee-for-service response to the 2017 Southern California wildfires

Note: This article was revised April 2, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired March 3, 2018. All other information remains the same. This information was previously published in the [December 2017 Medicare B Connection](#), pages 40-41.

Provider type affected

This *MLN Matters*[®] special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries, who were affected by the December 2017 wildfires in the state of California.

Provider information available

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of the December 2017 Wildfires, an emergency exists in the state of California.

On December 11, 2017, Acting Secretary Hargan of the Department of Health & Human Services declared that a public health emergency (PHE) exists in the state of California retroactive to December 4, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On December 13, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the state of California retroactive to December 4, 2017, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 waiver by following

the instructions available at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf>.

Note: The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired March 3, 2018.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed MACs as follows:

Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of California retroactive to December 4, 2017, for the duration of the emergency. In accordance with CR 6451, use of the “DR” condition code and the “CR” modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

The most current information is available at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html>.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the state of California. These Q&As are displayed in two files:

- One file addresses policies and procedures that are **See SOUTHERN**, page 23

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If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

Date of change	Description
April 2, 2018	The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired January 5, 2018.

Date of change	Description
November 1, 2017	This article was revised to add information regarding the exceptions granted for certain Medicare quality reporting and value-based purchasing programs.
October 18, 2017	Initial article released.

MLN Matters[®] Number: SE17035
 Related CR Release Date: April 2, 2018
 Related CR Transmittal Number: N/A
 Related Change Request (CR) Number: N/A
 Effective Date: N/A
 Implementation Date: N/A

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applicable **without** any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency.

- Another file addresses policies and procedures that are applicable **only with** approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved individual 1135 waivers requested by providers for California.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

- Q&As applicable **without any Section 1135** or other formal waiver are available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf.
- Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf>.

Waiver for California

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following waiver in the affected areas of California. **Individual facilities do not need to apply for the following approved waiver.**

Skilled nursing facilities

- 1812(f): This waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).
- In addition, the waiver provides temporary emergency coverage of SNF services that are not post-hospital SNF services under the authority in §1812(f) of the Social Security Act (the Act), for those people who are evacuated, transferred, or otherwise dislocated as a result of the effects in the state of California, in December 2017. In addition, this waiver provides authority under §1812(f) of the Act to provide coverage for extended care services which will not require a new spell of illness in order to renew provision of services by a SNF. These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under §1135 of the Act in connection with the effects of the wildfires in the state of California in December 2017. Accordingly, both the effective date and expiration date for these temporary emergency policies are the same as those specified pursuant

to the §1135 waivers. Further, unlike the policies authorized directly under the §1135 waiver authority itself, the two policies described above would not be limited to beneficiaries who have been relocated within areas that have been designated as emergency areas. Instead, the policies would apply to all beneficiaries who were evacuated from an emergency area as a result of the effects of the wildfires in California in December 2017, regardless of where the “host” SNF providing post-disaster care is located.

Administrative relief

Appeal administrative relief for areas affected by California wildfires

If you were affected by the California wildfires and are unable to file a timely appeal, respond to pending requests for documentation, or experience an interruption in the receipt of the remittance advice (RA) that lists the initial determination(s), please contact your MAC.

Requesting an 1135 Waiver

Information for requesting an 1135 waiver is available at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf>.

More information is available in the 1135 Waiver letter, which is posted in the *Downloads* section at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html>.

Additional information

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

Document history

Date of change	Description
April 2, 2018	This article was revised April 2, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired March 3, 2018. All other information remains the same.
December 18, 2017	Initial article released.

MLN Matters® Number: SE17037
 Article Revised Date: April 2, 2018
 Related CR Transmittal Number: N/A
 Related Change Request (CR) Number: N/A
 Effective Date: N/A
 Implementation Date: N/A

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Retired LCD

Topical photosensitizers used with PDT for actinic keratoses and certain skin cancers – retired Part A and Part B LCD

LCD ID number: L33414 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for topical photosensitizers used with PDT for actinic keratoses and certain skin cancers, it was determined that this LCD is no longer required. Therefore, the LCD and the associated coding guidelines are being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after April 10, 2018**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the



“Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, [click here](#).

Revisions to LCD

Biofeedback – revision to the Part A and Part B LCD

LCD ID number: L33615 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for biofeedback has been updated to revise language in the “Limitations of Coverage” section of the LCD.

Effective date

The LCD revision is effective for claims processed **on or after April 3, 2018**. LCDs are available through the CMS

Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Intravenous immune globulin – revision to the Part A and Part B LCD

LCD ID number: L34007 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the intravenous immune globulin local coverage determination (LCD), it was determined that the italicized language in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD does not represent a quotation from a Centers for Medicare & Medicaid Services (CMS) source. Therefore, this LCD has been revised to remove the italics from the language.

Effective date

This LCD revision is effective for services rendered **on or after April 12, 2018**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, [click here](#).

Magnetic resonance angiography (MRA) – revision to the Part A and Part B LCD

LCD ID number: L34372 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an external correspondence, the local coverage determination (LCD) for magnetic resonance angiography (MRA) was revised in the “CPT®/HCPCS Codes” section of the LCD to remove language referring to hospital outpatient prospective payment system (OPPS) and ambulatory surgical centers (ASCs). All the “C” procedure codes listed in the LCD are billable to hospital OPPS and ASCs. Therefore, the “CPT®/HCPCS Codes” section of the LCD was revised to consolidate the Part A and Part B groups that support medical necessity and groups that do not support medical necessity.

Effective date

This LCD revision is effective for claims processed **on or after April 12, 2018**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Vertebroplasty, vertebral augmentation; percutaneous – revision to the Part A and Part B LCD

LCD ID number: L34976 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an external correspondence, the vertebroplasty, vertebral augmentation; percutaneous local coverage determination (LCD) was revised in the “CPT®/HCPCS Codes” section of the LCD to remove Current Procedural Terminology (CPT®) code 76380. The remaining procedure codes listed in the LCD are inclusive of all imaging guidance.

In addition, based on an annual review of the LCD, it was determined that the language in the “Coverage Indications, Limitations, and/or Medical Necessity” section of the LCD does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, this LCD is being revised to assure consistency with the manual language.

Effective date

The LCD revision to remove CPT® code 76380 is effective for claims processed **on or after April 17, 2018**. The LCD revision to assure consistency with manual language is effective for services rendered **on or after April 17, 2018**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Additional Information

Noncovered services – revision to the Part A and Part B coding guidelines article (A54675)

LCD ID number: L33777 (Florida, Puerto Rico/ U.S. Virgin Islands)

The noncovered services local coverage determination (LCD) “coding guidelines” article is revised to remove deleted Current Procedural Terminology (CPT®) code 35452 from the “Procedures for Part B” section of the coding guidelines.

Effective date

The LCD revision is effective for claims processed **on or**

after April 12, 2018, for services rendered **on or after January 1, 2017**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, [click here](#).

Upcoming provider outreach and educational events

Topic: Psychiatric and psychotherapy services (B)

Date: Tuesday, May 15
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

<https://medicare.fcso.com/Events/0402691.asp>

Topic: Medicare Part B changes and regulations

Date: Wednesday, June 13
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

<https://medicare.fcso.com/Events/0402681.asp>

Note: Unless otherwise indicated, designated times for educational events are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at <https://gm1.geolearning.com/geonext/fcso/opensite.geo>, log on to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event.

First-time User? Set up an account by completing [Request User Account Form](#) online. Providers who do not have yet a national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant’s Name: _____

Registrant’s Title: _____

Provider’s Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, medicare.fcso.com, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.



The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*[®] is an official *Medicare Learning Network*[®] (MLN) – branded product that contains a week’s worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the *MLN Connects*[®] to its membership as appropriate.

MLN Connects[®] for March 29, 2018

MLN Connects[®] for March 29, 2018

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News & Announcements

- Patients Over Paperwork: Empowering Patients Through Data
- MIPS Data Submission Deadline: March 31
- Transitions from Hospice Care, Followed by Death or Acute Care Draft Measure: Comment Period Ends April 25
- Open Payments Review and Dispute Period: April 1 through May 15
- Qualified Medicare Beneficiary Claims: Replacement RAs
- MACRA Patient Relationship Categories and Codes
- Advanced Diagnostic Laboratory Tests: Applications and Guidance
- HIMSS18 Presentations
- Hospice Quality Reporting Program Video Series: Navigating HQRP Websites
- Hospice Item Set Coding Video Series
- Physician Compare Quality Measure TEP Summary Report
- Administrative Simplification: Reaching Compliance with ASETT Video

Provider Compliance

- Provider Compliance Tips for Diabetic Test Strips

Upcoming Events

- Comparative Billing Report on Spinal Orthoses Suppliers Webinar – May 2
- LTCH Quality Reporting Program In-Person Training Event – May 8 and 9
- IRF Quality Reporting Program In-Person Training Event – May 9 and 10



Medicare Learning Network Publications & Multimedia

- Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018 MLN Matters Article – New
- Adjustments to QMB Claims Processed under CR 9911 MLN Matters Article – New
- April Quarterly Update for 2018 DMEPOS Fee Schedule MLN Matters Article – New
- Low Volume Appeals Settlement Call: Audio Recording and Transcript – New
- Open Payments Call: Audio Recording and Transcript – New
- E/M Services Listening Session: Audio Recording and Transcript – New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article – Revised
- April 2018 I/OCE Specifications Version 19.1 MLN Matters Article – Revised
- April 2018 Update of the Hospital OPPS MLN Matters Article – Revised

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MLN Connects® for April 5, 2018

MLN Connects® for April 5, 2018

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News & Announcements

- New Medicare Card Project – Important Updates
- Bipartisan Budget Act: CMS Reprocessing Impacted Claims
- Reducing Provider Burden: Send us Your Feedback
- MIPS Group Web Interface and CAHPS Survey: Register by June 30
- MIPS APM: Resources for Performance Year 2018
- Medicare Diabetes Prevention Program: New Resources
- Administrative Simplification: Electronic Transactions
- Opioids: CDC Online Training Series
- Opioid Overdoses Treated in Emergency Departments: CDC Vital Signs Report
- Help Prevent Alcohol Misuse or Abuse
- Reduce the Risk of Falls in Elderly Patients

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities — Reminder

Claims, Pricers & Codes

- HCPCS Code Set Modifications

Upcoming Events

- Cultural Competence: Meeting LTSS Needs of Beneficiaries Webinar — April 12
- Safe and Effective Use of Medications in Older Adults Webinar — April 18

MLN Connects® for April 12, 2018

MLN Connects® for April 12, 2018

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News & Announcements

- Help Your Medicare Patients Avoid and Report Scams
- 2018 MIPS Eligibility Tool
- Draft 2019 QRDA Category I Schematron: Submit Comments by April 20
- Home Health Utilization and Payment Data
- National Health Care Decisions Day is April 16

Provider Compliance

- Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction

Upcoming Events

- Opioids Forum: Strategies and Solutions for Minority Communities — April 25
- Medicare Cost Report e-Filing System Webcast — May 1

- Managing Older Adults with Substance Use Disorders Webinar — May 16

Medicare Learning Network Publications & Multimedia

- Institutional Billing for No Cost Items MLN Matters Article — New
- Proper Coding for Specimen Validity Testing Billed in Combination with Drug Testing MLN Matters Article — New
- SNF ABN MLN Matters Article — New
- SNF Value-Based Purchasing Program Updated MLN Matters Article — New
- Dementia Care Call: Audio Recording and Transcript — New
- Medicare FFS Response to the 2017 California Wildfires MLN Matters Article — Updated
- Medicare FFS Response to the 2017 Southern California Wildfires MLN Matters Article — Updated
- Inpatient Psychiatric Facility PPS Booklet — Revised
- Medicare Enrollment for Providers Who Solely Order, Certify, or Prescribe Booklet — Revised
- 2018 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — Revised
- Medicare Parts A & B Appeals Process Booklet — Reminder
- Looking for Educational Materials?

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Medicare Learning Network Publications & Multimedia

- Increased Ambulance Payment Reduction for Non-Emergency BLS Transports to and from Renal Dialysis Facilities MLN Matters Article — New
- New Waived Tests MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Modifications to the Implementation of the PWK Segment of the esMD System MLN Matters Article – Revised
- Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018 MLN Matters Article — Revised
- Revised and New Modifiers for Oxygen Flow Rate MLN Matters Article — Revised
- April 2018 MLN Catalog – Revised
- Medicare Home Health Benefit Booklet — Revised

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MLN Connects® for April 19, 2018

MLN Connects® for April 19, 2018

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News & Announcements

- New Medicare Card: New Numbers Are Confidential
- Market Saturation and Utilization Data Tool
- MIPS Study on Burdens Associated with Reporting Quality Measures: Apply by April 30
- IMPACT Act Transfer of Health Measures: Public Comment Period Ends May 3
- PEPPERS Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
- National Minority Health Month: Partnering for Health Equity

Provider Compliance

- Ophthalmology Services: Questionable Billing and Improper Payments

Claims, Pricers & Codes

- April 2018 OPPS Pricer File

Upcoming Events

- Medicare Cost Report e-Filing System Webcast — May 1
- LTCH Quality Reporting Program In-Person Training Event — May 8 and 9
- IRF Quality Reporting Program In-Person Training Event — May 9 and 10

Medicare Learning Network Publications & Multimedia

- Quarterly Update to the NCCI PTP Edits, Version 24.2 MLN Matters Article — New



- Change in Type of Service for CPT Code 77067 MLN Matters Article — New
- Ambulance Transportation for SNF Resident in Stay Not Covered by Part A MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Guidelines for Teaching Physicians, Interns, and Residents Booklet — Revised
- Billing Information for Rural Providers and Suppliers Booklet — Revised
- ICD-10-CM/PCS: The Next Generation of Coding Booklet — Reminder
- General Equivalence Mappings FAQs Booklet — Reminder
- Critical Access Hospital Booklet — Reminder
- Learn About Medicare Policy

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Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at <https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html>. Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU.

Phone numbers

Customer service

866-454-9007
877-660-1759 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

866-454-9007
877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

866-454-9007
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 2525
Jacksonville, FL 32231-0019

Redeterminations

Medicare Part B Redetermination
P.O. Box 2360
Jacksonville, FL 32231-0018

Redetermination of overpayments

Overpayment Redetermination, Review Request
P.O. Box 45248
Jacksonville, FL 32232-5248

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries

General inquiry request
P.O. Box 2360
Jacksonville, FL 32231-0018

Email: EDOC-CS-FLINQB@fcsso.com>>
Online form: <https://medicare.fcso.com/Feedback/161670.asp>

Provider enrollment

Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 44141
Jacksonville, FL 32231-4141

Medicare Education and Outreach

Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Florida
P.O. Box 45268
Jacksonville, FL 32232-5268

Overnight mail and/or special courier service

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor
<https://medicare.fcso.com>

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services
<https://www.cms.gov>

E-learning Center
<https://gm1.geolearning.com/geonext/fcso/opensite.geo>

Beneficiaries

Centers for Medicare & Medicaid Services
<https://www.medicare.gov>

Phone numbers

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866-454-9007

877-660-1759 (speech and hearing impaired)

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Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

866-454-9007

877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614

877-660-1759 (TTY)

The SPOT help desk

855-416-4199

Email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims

P.O. Box 45098

Jacksonville, FL 32232-5098

Redeterminations

Medicare Part B Redetermination

P.O. Box 45024

Jacksonville, FL 32232-5024

Redetermination of overpayments

First Coast Service Options Inc.

P.O. Box 45091

Jacksonville, FL 32232-5091

Reconsiderations

C2C Innovative Solutions, Inc.

Part B QIC South Operations

ATTN: Administration Manager

PO Box 45300

Jacksonville, FL 32232-5300

General inquiries

First Coast Service Options Inc.

P.O. Box 45098

Jacksonville, FL 32232-5098

Email: EDOC-CS-FLINQB@fcsso.com>>

Online form: <https://medicare.fcsso.com/Feedback/161670.asp>

Provider enrollment

Provider Enrollment

P.O. Box 44021

Jacksonville, FL 32231-4021

Medical policy

Medical Policy and Procedure

P.O. Box 2078

Jacksonville, FL 32231-0048

Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.

P.O. Box 44078

Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C

P.O. Box 44071

Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery

P.O. Box 44141

Jacksonville, FL 32231-4141

Medicare Education and Outreach

Medicare Education and Outreach

P.O. Box 45157

Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints

P.O. Box 45087

Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA USVI

P.O. Box 45073

Jacksonville, FL 32231-5073

Special courier service

First Coast Service Options Inc.

532 Riverside Avenue

Jacksonville, FL 32202-4914

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor

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Centers for Medicare & Medicaid Services

<https://www.cms.gov>

E-learning Center

<https://gm1.geolearning.com/geonext/fcsso/opensite.geo>

Beneficiaries

Centers for Medicare & Medicaid Services

<https://www.medicare.gov>

Phone numbers

Customer service

1-877-715-1921
1-888-216-8261 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)
904-361-0407 (FAX)

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

877-715-1921
877-660-1759 (TTY)

General inquiries

877-715-1921
888-216-8261 (TTY)

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

877-715-1921
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 45036
Jacksonville, FL 32232-5036

Redeterminations

Medicare Part B Redetermination
P.O. Box 45056
Jacksonville, FL 32232-5056

Redetermination of overpayments

First Coast Service Options Inc.
P.O. Box 45015
Jacksonville, FL 32232-5015

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries

First Coast Service Options Inc.
P.O. Box 45098
Jacksonville, FL 32232-5098

Email: EDOC-CS-PRINQB@fcsso.com
Online form: <https://medicare.fcsso.com/Feedback/161670.asp>

Provider enrollment

Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 45040
Jacksonville, FL 32231-5040

Medicare Education and Outreach

Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Puerto Rico
P.O. Box 45092
Jacksonville, FL 32232-5092,

Special courier service

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider

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Find your *other contractors* (e.g. DME, HHA, etc)

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E-learning Center
<https://gm1.geolearning.com/geonext/fcsso/opensite.geo>

Beneficiaries

Centers for Medicare & Medicaid Services
<https://www.medicare.gov>

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to First Coast Service Options Inc. account # (use appropriate account number). Do not fax your order; it must be mailed.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction N publications, in both Spanish and English, are available free of charge online at https://medicare.fcso.com/Publications_B/index.asp (English) or https://medicareespanol.fcso.com/Publicaciones/ (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2017 through September 2018.	40300260	\$33		
2018 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2018, are available free of charge online at https://medicare.fcso.com/Data_files/ (English) or https://medicareespanol.fcso.com/Fichero_de_datos/ (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note: Requests for hardcopy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	\$12		
Language preference: English [<input type="checkbox"/>] Español [<input type="checkbox"/>]				
<i>Please write legibly</i>			Subtotal	\$
			Tax (add % for your area)	\$
			Total	\$

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Atlanta, GA 30384-6443

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Phone: _____

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(Checks made to "purchase orders" not accepted; all orders must be prepaid)