Medicare A Connection
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
September 2016

In this issue

October update of the hospital outpatient prospective payment system

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs), including home health and hospice (HH&H) MACs, for services provided to Medicare beneficiaries and which are paid under the outpatient prospective payment system (OPPS).

Provider action needed

Change request (CR) 9768 describes changes to and billing instructions for various payment policies implemented in the October 2016 OPPS update. It identifies the healthcare common procedure coding system (HCPCS), ambulatory payment classification (APC), HCPCS modifier, status indicators (SIs), and revenue code additions, changes, and deletions that are reflected in the October 2016 integrated outpatient code editor (I/OCE) and OPPS Pricer. Make sure that your billing staffs are aware of these changes.

Key points of CR 9768

Key changes to and billing instructions for various payment policies implemented in the July 2016 OPPS updates are as follows:

New separately payable procedure code

Effective October 1, 2016, a new HCPCS code C9744 has been created. See Table 1.

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Contents

The *Medicare A Connection* is published monthly by First Coast Service Options Inc.'s Provider Outreach & Education division to provide timely and useful information to Medicare Part A providers.

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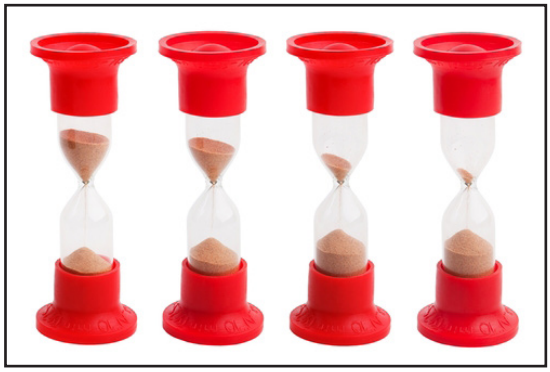
Articles included in the *Medicare A Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

Documentation needed to qualify for timely filing limit exceptions

Section 6404 of the Patient Protection and Affordable Care Act (the Affordable Care Act or ACA) reduced the maximum period for submission of all Medicare fee-for-service claims to no more than 12 months – one calendar year – after the date of service. This policy is effective for services furnished on or after January 1, 2010; claims for services furnished prior to that date were required to be submitted no later than December 31, 2010.

Effective on/after January 1, 2016, providers must utilize the new reopening process (TOB XXQ) when the need for correction is discovered beyond the claim timely filing limit; an adjustment bill (TOB XX7) is not allowed.



In an effort to streamline and standardize the process for claim reopening with the 'Q" frequency code and adjustment reason codes (ARC), the Centers for Medicare & Medicaid Services (CMS) issued *MLN Matters*® article *MM8581*.

CMS released special edition *MLN Matters*® article *SE1426* to assist providers with coding instructions and billing scenarios for submitting requests to reopen claims that are beyond the claim filing timeframe.

(**Note**: The Administrative Billing Errors category is being removed from the process below, you must utilize the new reopening process to correct claims with dates of service beyond the timely filing limit. Please refer to the *MLN Matters*® referenced above for complete information on the new reopening process.)

The following exceptions apply to the time limit for filing **initial** Medicare claims:

- Retroactive Medicare entitlement
- Retroactive Medicare entitlement involving state Medicaid agencies
- Retroactive disenrollment from a Medicare Advantage plan or program of all-inclusive care for the elderly (PACE) provider organization

Retroactive Medicare entitlement

- An official letter notifying the beneficiary of Medicare entitlement and the effective date of the entitlement, **and**
- Documentation describing the service(s) furnished to the beneficiary and the date of the furnished service(s), **or**
- If an official Social Security Administration (SSA) letter cannot be provided, First Coast Service Options, Inc. (First Coast) will check the common working file (CWF) database and may interpret the CWF date of accretion and the CWF Medicare entitlement date for a beneficiary in order to verify retroactive Medicare entitlement.

Retroactive Medicare entitlement involving state Medicaid agencies (state buy-in)

- Documentation showing the date that the state Medicaid agency recouped money from the provider/supplier, **and**
- Documentation verifying that the beneficiary was retroactively entitled to Medicare to or before the date of the furnished service (i.e., the official letter to the beneficiary), **and**
- Documentation verifying the service/s furnished to the beneficiary and the date of the furnished service(s).

Retroactive disenrollment from a Medicare Advantage plan or PACE provider organization

- Evidence of prior enrollment of the beneficiary in an MA plan or PACE provider organization, **and**
- Evidence that the beneficiary, the provider, or supplier was notified that the beneficiary is no longer enrolled in the MA plan or PACE provider organization, **and**
- The effective date of the disenrollment; **and**
- Documentation showing the date the MA plan or PACE provider organization recouped money from the provider or supplier for services furnished to a disenrolled beneficiary.

Click here for information on submitting an appeal.

Customer service process for time limit exceptions

First Coast has undertaken an initiative to provide an easier mechanism for handling requests from providers to extend the timely filing requirement on claims that exceed the provision. Effective January 1, 2016, as previously mentioned, the administrative billing errors category has been removed from the process listed below. The following guidelines remain the same for all other requests from providers to extend the timely filing extension on their claims:

- Medicare providers must complete the *Request for Telephone Claim Override Timeliness Form for Part A*, attach the appropriate documentation and a brief explanation of the reason for delayed filing. A limit of one form can be submitted per fax request. Fax the request to 904-361-0693. *Click here to access the form*. **Note**: If any part of the form is not legible, the timely filing limit for your claim(s) will not be overridden.
- First Coast written inquiry representatives will retrieve the documentation, review it, and issue an approval

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Processing Issues

Mass adjustments to correct IPPS claim payments

Issue

With the implementation of change request (CR) 8900 in October 2014, fiscal year (FY) 2015 inpatient prospective payment system (IPPS) and long term care hospital (LTCH) PPS changes, certain inpatient claims priced incorrectly when loading both the state code and provider wage index codes for providers subject to IPPS. This problem was corrected June 8, 2015.

Resolution

- Mass adjustments were performed on all claims that met the following criteria:
- Claims with processed dates after October 5, 2014, through to June 8, 2015, with discharge date after October 5, 2014, through to June 8, 2015.
- Type of bill (TOB) 11x
- Provider range xx0001-xx0999 where xx is a specific state code including Florida (10) and Puerto Rico (40)

Status/date resolved

Closed. Adjustments were completed in July 2016.

Provider action

None.

Current processing issues

Here is a link to a table of *current processing issues* for both Part A and Part B.

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or disapproval letter to the provider in response to the timely filing request. The approval or disapproval response will be sent to the FAX number provided on the Request for Telephone Claim Override Timeliness Form for Part A. Be advised that this process could take up to 45 business days to complete. **Do not call the contact center**.

If a claim filing extension is granted, the approval letter will instruct the provider to file a new claim. The unique approval number, provided in the approval letter, and the date of the approval letter must be included in the remark section of the claim.

Additionally, the approval letter will include a date by which the new claim must be filed. Once the claim is filed, the approval number entered on the remark line and the receipt date of the claim will be compared to the list of approved numbers. If this information matches, the claims timely filing edit will then be overridden on the applicable claim. It is important to note that other edits may fail on the claim which may require that providers correct their billing and resubmit the claims.

If a claim filing extension is not granted, the reason for not granting the extension will be outlined in the letter.

It is important that the above outlined process be followed in its entirety as any deviations could result in documentation being returned and added delays in approvals.

Access the *timely filing request form*

Ambulance staffing requirements

Provider types affected

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

Provider action needed

Change request (CR) 9761, manualizes the 2016 revisions to the ambulance staffing requirements (80 FR 71078-71080) and provides clarifications on the definitions for ground ambulance services for advanced life support, level 1 (ALS1), ALS assessment, application for ALS, level 2 (ALS2), specialty care transport (SCT), paramedic intercept (PI), emergency response, and inter-facility transportation. Please make sure your billing staff is aware of these revisions.

Background

In the 2016 physician fee schedule final rule (80 FR 71078-71080), the Centers for Medicare & Medicaid Services (CMS) finalized without modification their proposals to revise:

1. 42 CFR 410.41(b) and the definition of basic life support (BLS) in 42 CFR 414.605, to require that all Medicare covered ambulance transports be staffed by at least two people who meet both the requirements of state and local laws where the services are being furnished, and the current Medicare requirements;
2. 42 CFR 410.41(b) and the definition of BLS in 42 CFR 414.605 to clarify that for BLS vehicles, one of the staff members must be certified at a minimum as an EMT-Basic; and
3. To delete the last sentence in the definition of BLS in 42 CFR 414.605, which sets forth examples of certain state law provisions.

CR 9761 updates Chapter 10, Sections 10.1.2; 30.1; and 30.1.1 of the *Medicare Benefit Policy Manual* (Pub. 100-02) to incorporate these revisions.

Key points of CR 9761

BLS vehicles

BLS ambulances must be staffed by at least two people, who meet the requirements of state and local laws where the services are being furnished and where, at least one of whom must be certified at a minimum as an emergency medical technician-basic (EMT-basic) by the State or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. These laws may vary from state to state or within a state.

ALS vehicles

Advanced life support (ALS) vehicles must be staffed by at least two people, who meet the requirements of state and local laws where the services are being furnished and where at least one of whom must meet the vehicle staff requirements above for BLS vehicles and be certified as an EMT-intermediate or an EMT-paramedic by the state or local authority where the services are being furnished to perform one or more ALS services.

Ambulance services

There are several categories of ground ambulance services and two categories of air ambulance services under the fee schedule. (Note that “ground” refers to both land and water transportation.) All ground and air ambulance transportation services must meet all requirements regarding medical reasonableness and necessity as outlined in the applicable statute, regulations and manual provisions.

Advanced life support, level 1 (ALS1)

Definition: ALS1 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment by ALS personnel or at least one ALS intervention.

ALS assessment

Definition: An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient’s reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. In the case of an appropriately dispatched ALS emergency service, as defined below, if the ALS crew completes an ALS assessment, the services provided by the ambulance transportation service provider or supplier may be covered at the ALS emergency level, regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary.

ALS intervention

Definition: An ALS intervention is a procedure that is in accordance with state and local laws, required to be done by an emergency medical technician-intermediate (EMT-intermediate) or EMT-paramedic.

Application: An ALS intervention must be medically necessary to qualify as an intervention for payment for an ALS level of service. An ALS intervention applies only to ground transports.

Advanced life support, level 1 (ALS1) - emergency

Definition: When medically necessary, the provision of ALS1 services, in the context of an emergency response.

Advanced life support, level 2 (ALS2)

Definition: ALS2 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including at least three separate administrations of one or more medications by intravenous (IV) push/bolus or by continuous infusion (excluding crystalloid fluids) or ground ambulance

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transport, medically necessary supplies and services, and the provision of at least one of the following ALS2 procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

Application: Crystalloid fluids include but are not necessarily limited to 5 percent dextrose in water (often referred to as D5W), saline and lactated ringer's. To qualify for the ALS2 level of payment, medications must be administered intravenously. Medications that are administered by other means, for example, intramuscularly, subcutaneously, orally, sublingually, or nebulized do not support payment at the ALS2 level rate.

IV medications are administered in standard doses as directed by local protocol or online medical direction. It is not appropriate to administer a medication in divided doses in order to meet the ALS2 level of payment. For example, if the local protocol for the treatment of supraventricular tachycardia (SVT) calls for a 6 mg dose of adenosine, the administration of three 2 mg doses in order to qualify for the ALS 2 level is not acceptable.

The administration of an intravenous drug by infusion qualifies as one intravenous dose. For example, if a patient is being treated for atrial fibrillation in order to slow the ventricular rate with diltiazem and the patient requires two boluses of the drug followed by an infusion of diltiazem then the infusion would be counted as the third intravenous administration and the transport would be billed as an ALS 2 level of service.

The fractional administration of a single dose (for this purpose, meaning a "standard" or "protocol" dose) of a medication on three separate occasions does not qualify for ALS2 payment. In other words, the administering 1/3 of a qualifying dose three times does not equate to three qualifying doses to support claiming ALS2-level care. For example, administering one-third of a dose of X medication three times might = Y (where Y is a standard/protocol drug amount), but the same sequence does not equal three times Y. Thus, if three administrations of the same drug are required to claim ALS2 level care, each administration must be in accordance with local protocols; the run will not qualify at the ALS2 level on the basis of drug administration if that administration was not according to local protocol. The criterion of multiple administrations of the same drug requires that a suitable quantity of the drug be administered and that there be a suitable amount of time between administrations, and that both are in accordance with standard medical practice guidelines.

Examples of drug administration that help explain this policy are in the revised manual sections that are attached to CR 9761.

ALS personnel

Definition: ALS personnel are individuals trained to the level of the emergency medical technician-intermediate (EMT-intermediate) or paramedic.

Specialty care transport (SCT)

Definition: Specialty care transport (SCT) is the inter-facility transportation (as defined below) of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-paramedic with additional training.

Application: SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. The EMT-Paramedic level of care is set by each state. Medically necessary care that is furnished at a level above the EMT-Paramedic level of care may qualify as SCT.

To be clear, if EMT-paramedics - without specialty care certification or qualification - are permitted to furnish a given service in a state, then that service does not qualify for SCT. The phrase "EMT-paramedic with additional training" recognizes that a state may permit a person who is not only certified as an EMT-paramedic, but who also has successfully completed additional education as determined by the state in furnishing higher level medical services required by critically ill or injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide. "Additional training" means the specific additional training that a state requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

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Paramedic intercept (PI)

Definition: Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only basic life support (BLS) level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

Paramedic intercept services furnished on or after March 1, 1999, are payable separate from the ambulance transport when all the requirements in the following three conditions are met:

I. The intercept service(s) is:
   - Furnished in a rural area (as defined below) ;
   - Furnished under a contract with one or more volunteer ambulance services; and,
   - Medically necessary based on the condition of the beneficiary receiving the ambulance service.

II. The volunteer ambulance service involved must:
   - Meet Medicare's certification requirements for furnishing ambulance services;
   - Furnish services only at the BLS level at the time of the intercept; and,
   - Be prohibited by state law from billing anyone for any service.

III. The entity furnishing the ALS paramedic intercept service must:
   - Meet Medicare's certification requirements for furnishing ALS services; and,
   - Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

For purposes of the paramedic intercept benefit, a rural area is an area that is designated as rural by a state law or regulation or that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent version of the Goldsmith Modification). (The Goldsmith Modification is a methodology to identify small towns and rural areas within large metropolitan counties that are isolated from central areas by distance or other features). The current list of these areas is periodically published in the *Federal Register*. See the *Medicare Claims Processing Manual*, *Chapter 15*, Ambulance, Section 20.1.4, for payment of paramedic intercept services.

Inter-facility transportation

For purposes of SCT payment, an inter-facility transportation is one in which the origin and destination are one of the following:

- A hospital or skilled nursing facility (SNF) that participates in the Medicare program, or
- A hospital-based facility that meets Medicare's requirements for provider-based status.

Emergency response

Definition: Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call. The nature of an ambulance's response (whether emergency or not) does not independently establish or support medical necessity for an ambulance transport. Rather, Medicare coverage always depends on, among other things, whether the service(s) furnished is actually medically reasonable and necessary based on the patient's condition at the time of transport.

Additional information

The official instruction, CR 9761, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R226BP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

Document history

Date of change	Description
September 13, 2016	The article was revised due to a revised CR. The CR corrected the implementation date in the manual instruction section of the CR to December 12, 2016. The transmittal number, CR release date and the link to the CR also changed.
September 10, 2016	Initial article released

MLN Matters® Number: MM9761
Related Change Request (CR) #: CR 9761
Related CR Release Date: September 12, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R226BP
Implementation Date: December 12, 2016

Ninth update to coding revisions to national coverage determination

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9751 is the 9th maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, CR 8691, CR 9087, CR 9252, CR 9540, and CR 9631; while others are the result of revisions required to other NCD-related CRs released separately. *MLN Matters*® articles *MM7818*, *MM8109*, *MM8197*, *MM8691*, *MM9087*, *MM9252*, *MM9540*,and *MM9631* contain information pertaining to these CR's.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete general equivalence mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of the NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable as of October 1, 2015.

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed.

CR 9751 makes adjustments to the following NCDs:

- NCD 20.7 Percutaneous Transluminal Angioplasty (PTA)
- NCD 20.19 Ambulatory Blood Pressure Monitoring (ABPM)
- NCD 20.33 Transcatheter Mitral Valve Repair (TMVR) Therapy
- NCD 40.1 Diabetes Self-Management Training (DSMT)
- NCD 160.18 Vagus Nerve Stimulation (VNS)
- NCD 180.1 Medical Nutrition Therapy (MNT)
- NCD 190.3 Cytogenetic Studies
- NCD 220.6.17 FDG PET for Solid Tumors
- NCD 220.6.20 PET Beta Amyloid in Dementia/ Neurological/ Disorders
- NCD 230.18 Sacral Nerve Stimulation (SNS) for Urinary Incontinence
- NCD 260.1 Adult Liver Transplants

The spreadsheets for the above NCDs are available at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9751.zip*.

Remember that coding and payment are areas of the Medicare program that are separate and distinct from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate:

- Remittance advice remark codes (RARC)
  - N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered; with
- Claim adjustment reason codes (CARC)
  - 50 - These are non-covered services because this is not deemed a "medical necessity" by the payer;
  - 96 - Non-covered charge(s); or
  - 119 Benefit maximum for this time period has been reached.

Group code PR (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed advance beneficiary notice (ABN) is on file). 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).

Additional information

The official instruction, CR 9751, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1708OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9751
Related Change Request (CR) #: CR 9751
Related CR Release Date: August 19, 2016
Effective Date: January 1, 2017 - Unless otherwise noted
Related CR Transmittal #: R1708OTN
Implementation Date: January 3, 2017

Editing update for screening for sexually transmitted infections

***Note**: This article was revised September 8, 2016, due to an updated change request (CR). The CR modified the effective date and made changes to the Background section to reflect that change. The transmittal number CR release date and link to the transmittal also changed. All other information remains the same. This information was previously published in the August 2016 Medicare A Connection, page 8.*

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs and durable medical equipment MACs (DME MACs) for services to Medicare beneficiaries.

Provider action needed

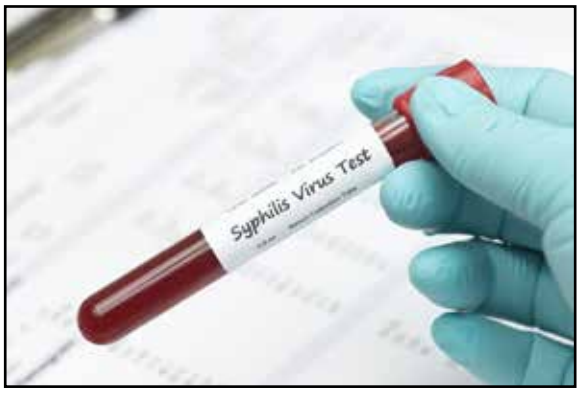
CR 9719 informs MACs about the changes to certain edits that should have been written as line level denials rather than claim denials if you do not report the appropriate diagnosis code. Make sure that your billing staffs are aware of these changes.

Background

CR 7610, Transmittal 2476, provided billing instructions for Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling to prevent STIs. It was brought to Centers for Medicare & Medicaid Services (CMS) attention that 072x type of bill (TOB) claims containing STI codes and diagnosis V74.5 or V73.89, **with dates of service on or after October 1, 2015**, were incorrectly being denied. Per *CR 7610*, current editing would deny a claim for STI services submitted with diagnosis code V74.5 or V73.89 on a TOB other than 13x, 14x, or 85x (without revenue code 096x, 097x, or 098x).

To correct these problems, CR 9719 instructs the MACs to modify existing editing to deny line items on claims for STIs (CPT® 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800, 87590, 87591, 87850, 86592, 86593, 86780, 87340, or 87341) containing ICD-9 code V74.5 or V73.89 (for claims with dates of service before October 1, 2015) and ICD-10 code Z11.3 or Z11.59 (with dates of service on or after October 1, 2015) when submitted on a TOB other than 13x, 14x, or 85x (without revenue code 096x, 097x, or 098x). When denying these line items, MACs will use the following messages:

- **CARC 170**: "Payment is denied when performed/ billed by this type of provider. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N95**: "This provider type/provider specialty may not bill this service."



- **Group code PR** (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed advanced beneficiary notice (ABN) is on file).
- **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).

CR 9719 represents no change in policy. CMS is modifying existing editing to ensure correct payment for claims related to STIs.

Additional information

The official instruction, CR 9719, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1713OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork-MLN/MLNMattersArticles/index.html*.

The article related to CR 7610 is at *https://www.cms.gov/Outreach-andEducation/Medicare-Learning-NetworkMLN/MLNMattersArticles/Downloads/MM7610.pdf*.

MLN Matters® Number: MM9719 *Revised*
Related Change Request (CR) #: CR 9719
Effective Date: For claims with dates of service on or after October 1, 2015
Related CR Release Date: September 1, 2016
Related CR Transmittal #: R1713OTN
Implementation Date: January 3, 2017

This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage web page at *http://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the First Coast eNews mailing list. Simply go to *http://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

More information

For more information, or, if you do not have internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? First Coast's LCD lookup, available at *http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp*, helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

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

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

"We are aware of the changes in medical policies via First Coast *eNews* we receive every week. We are continuously monitoring to identify changes and thus prevent claims to be denied."

Sign up for *eNews* by clicking *here*.

– Luis Rodríguez Félix,
Billing manager, Ashford Presbyterian Community Hospital

New LCDs

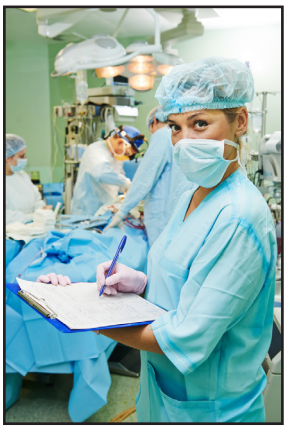
Aortography and peripheral angiography – new Part A and Part B LCD

LCD ID number: L36767 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for aortography and peripheral angiography was developed based on issues identified during medical review related to coverage criteria, coding requirements, and documentation in the medical record not supporting invasive diagnostic arteriography procedures performed for the purpose of evaluating vascular disease. Due to the risk of a high dollar claim payment error and to provide guidance to the First Coast Medical Review teams during medical reviews, the new LCD addresses invasive diagnostic arteriography episode of care.

Furthermore, the existing renal angiography LCD (L33715) was incorporated when creating this new LCD and will be retired when the new LCD becomes effective.

Effective date



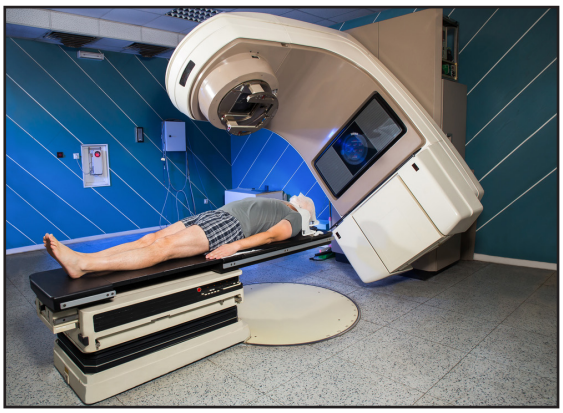
This new LCD is effective for services rendered **on or after October 31, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting “Attachments” 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*.

Intensity modulated radiation therapy – new Part A and Part B LCD

LCD ID number: L36773 (Florida, Puerto Rico/ U.S. Virgin Islands)



The local coverage determination (LCD) L33378 for intensity modulated radiation therapy (IMRT) was retired on April 7, 2016, due to outdated coding information. The LCD had language stating that simulation-aided field setting complex (CPT® code 77290) during a course of IMRT was appropriate. This statement was mismarketed as an allowance of separate payment of simulation–aided field settings and the treatment plan. Simulation field settings for IMRT should not be reported separately per correct coding initiative (CCI) manual and CMS change request 9658 (effective July 1, 2016), which states that payment for certain services (e.g., CPT® codes 77280, 77285, 77290 for therapeutic radiology simulation-aided field settings) is bundled in the IMRT treatment planning CPT® code 77301. The new LCD L36773 Intensity Modulated Radiation Therapy includes a “Limitations” section and an updated “Indications” section to include most current practice guidelines on IMRT from the American Society for Radiation Oncology.

Effective date

This new LCD is effective for services rendered **on or after November 7, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting “Attachments” 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*.

Prostatic urethral lift (PUL) – new Part A and Part B LCD

LCD ID number: L36775 (Florida, Puerto Rico/ U.S. Virgin Islands)

A local coverage determination (LCD) for prostatic urethral lift (PUL) was developed to outline indications and limitations of coverage and/or medical necessity, appropriate CPT® codes, and applicable ICD-10-CM diagnosis codes. Several of the Medicare administrative contractors (MACs) are allowing claims (silent on coverage criteria- as such, payment is not considered a statement of coverage) and others have policy criteria in play or plan to address criteria for limited coverage (via the local coverage determination process). The Urolift procedure has randomized controlled study data in the public domain, though clearly there are issues with study limitations such as, duration of follow-up to identify a long term problem, low number of patients included in studies, indirectness of evidence, and likely publication bias. Therefore, the quality of evidence is considered to be low. However, based on input from practicing urologists in Florida who concur with the need for on-going collection of data to examine longer term outcomes, but also feel there is a niche for certain qualified Medicare patients, MAC jurisdiction N (JN) developed this draft LCD to address limited coverage criteria for the subset of patients who have co-morbidities that increase risk of complications of a more invasive procedure such as transurethral resection of the prostate or TURP.

Effective date

This new LCD is effective for services rendered **on or after October 31, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" 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 LCDs

Computed tomographic angiography of the chest, heart and coronary arteries – revision to the Part AB LCD

LCD ID number: L33282 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for computed tomographic angiography of the chest, heart and coronary arteries was revised to add ICD-10-CM diagnosis codes I35.0, I35.1, I35.2, I35.8, I48.0, I48.1, I48.2, and I48.91 for Current Procedural Terminology (CPT®) codes 75571, 75572, 75573, and 75574 in the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after September 6, 2016**, for services rendered **on or after October 01, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" 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*.

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.

Intravenous Immune Globulin – revision to the Part AB LCD

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

The local coverage determination (LCD) for intravenous immune globulin (IVIG) was revised to include IVIG as an alternative treatment for patients with autoimmune optic neuropathy unresponsive to corticosteroids in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. Also, ICD-10-CM code H46.8 was added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

The effective date for the revision is for dates of service **on or after September 8, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" 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*.

Syphilis Test – revision to the Part AB LCD

LCD ID number: L33754 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for syphilis test was revised to add the following diagnoses for posterior uveitis/ chorioretinal inflammation to the "ICD-10 Codes that Support Medical Necessity" section of the LCD: H30.011-H30.013, H30.021-H30.023, H30.031-H30.033, and H30.041-H30-043.

Effective date

The effective date for the revision is for dates of service **on or after August 29, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" 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*.

Medicare A Connection subscription

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Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published in the current fiscal year.

To order an annual subscription, complete the *Medicare A Connection Subscription Form*, ***located here***.

Additional Information

Self-administered drug (SAD) list – revision to the Part A and Part B article

LCD ID number: A52571 (Florida, Puerto Rico/ U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered on or after October 31, 2016, the following drugs have been added to the MAC Jurisdiction N (JN) SAD list:

- Alprostadil Urethral Suppository (MUSE™) J0275
- Mecasermin (Increlex) J2170
- Octreotide Non-Depot form (Sandostatin) J2354
- Pasireotide long acting 1 mg-J2502
- Urofollitropin (Bravelle®) J3355
- Interferon Alfacon1, Recombinant 1 Microgram (Infergen) J9212
- Interferon, alfa-2a, Recombinant 3 million units- J9213
- Interferon, GAMMA 1b, 3 Million units (Actimmune)-J9216
- Pegylated Interferon alfa-2b (PegIntron) (C9399, J3491, J3590)
- Pramlintide Acetate (Symlin) (C9399, J3490, J3590)
- TriiMix (C9399, J3490, J3590)
- (Liraglutide (Saxenda®) (C9399, J3490, J3590)
- Pegvisomant (Somavert) (C9399, J3490, J3590)

- Daclizumab (Zinbryta) (C9399, J3490, J3590)
- Insulin glargine (Toujeo) (C9399, J3490, J3590)
- Sermorelin Acetate-Q0515
- TALTZ (ixekizumab) (C9399, J3490, J3590)

The evaluation of drugs for addition to the self-administered drug (SAD) list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options Inc. (First Coast) current SAD lists are available through the CMS Medicare Coverage Database at: *https://www.cms.gov/medicare-coverage-database/indexes/article-list.aspx?Cntrctr=368&name=&DocStatus=SAD&&ContrVer=1&CntrctrSelected=368*1&bc=AgABAAEAAAAAAA%3d%3d&#ResultsAnchor*.

The First Coast Service Options Inc. (First Coast) future effective SAD lists are available through the CMS Medicare Coverage Database at: *https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52571&ver=30&Cntrctr=368&name=&DocStatus=SAD&ContrVer=1&CntrctrSelected=368*1&bc=AgABAAMAEAAAAA%3d%3d&Z*.

CINQAIR® billing instructions

On March 23, 2016, the U. S. Food and Drug Administration approved reslizumab (CINQAIR® injections, Teva Pharmaceutical Industries Ltd.) as an add-on-maintenance treatment for the treatment of patients with severe asthma aged 18 years and older and with an eosinophilic phenotype.

The recommended dose and schedule for CINQAIR is 3mg/kg once every four weeks administered intravenous infusion® over 20-50 minutes.

Submit:

HCPCS code: C9399

Diagnoses: J45.20-J45.998 (Asthma), and J82 (Pulmonary eosinophilia, not elsewhere classified)

Narrative field or electronic equivalent:

Name of the drug, strength, dosage and NDC number.

Updates to self-dialysis training, retraining, and nocturnal hemodialysis

Provider types affected

This *MLN Matters*® article is intended for end-stage renal disease (ESRD) facilities that submit claims to Medicare administrative contractors (MACs) for ESRD services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9609 implements condition code 87 that can be used on the 72x type of bill for ESRD facilities to indicate that the ESRD beneficiary is receiving a retraining treatment. CR 9609 also introduces the UJ modifier to show the provision of nocturnal hemodialysis. Make sure your billing staffs are aware of these changes.

Background

Effective January 1, 2011, The Centers for Medicare & Medicaid Services (CMS) implemented the ESRD prospective payment system (PPS) based on the requirements of Section 1881(b)(14) of the Social Security Act (the Act) as amended by Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA). The ESRD PPS provides a single per-treatment payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment.

The ESRD PPS provides a home and self-dialysis training add-on payment adjustment when the beneficiary is training for home or self-dialysis. The training add-on payment adjustment is applied to a maximum of 25 treatments for hemodialysis and 15 treatments for peritoneal dialysis. After the initial training is completed, ESRD facilities can receive the training add-on payment adjustment when ESRD beneficiaries are retraining. Currently, ESRD facilities report the 73 condition code for both training and retraining.

Nocturnal hemodialysis - Effective January 1, 2017

Nocturnal hemodialysis is performed either at home or in a dialysis facility while the patient is sleeping. It is a longer and slower form of hemodialysis that can be >five hours per treatment, three to seven days a week.

Currently under the ESRD PPS, there is no claim processing mechanism for ESRD facilities to recognize that an ESRD beneficiary is receiving nocturnal hemodialysis. CR 9609 implements the UJ modifier (services provided at night), for ESRD facilities to append on the dialysis line to indicate that the treatment furnished is nocturnal hemodialysis, that is, longer and slower hemodialysis that can be performed at home or in-facility for >five hours per treatment, three-seven days a week.

Home and self-dialysis training add-on payment adjustment - effective April 1, 2017

There are no changes to the home and self-dialysis training policy discussed in the *Medicare Benefit Policy Manual*, Chapter 11, Section 30.2. CR 9609 does implement a treatment cap for the number of training treatments furnished to ESRD beneficiaries. ESRD beneficiaries that receive training for hemodialysis should not receive more than 25 training treatments.

ESRD beneficiaries that receive training for continuous cycling peritoneal dialysis and continuous ambulatory peritoneal dialysis should not receive more than 15 training treatments.

Home and self-dialysis retraining - effective July 1, 2017

There are no changes to the home and self-dialysis retraining policy discussed in the *Medicare Benefit Policy Manual*, Chapter 11, Section 30.2.E. CR 9069 does implement condition code 87 (ESRD self-care retraining) that can be used on the 72x type of bill for ESRD facilities to indicate that the ESRD beneficiary is receiving a retraining treatment.

Additional information

The official instruction, CR 9609, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1715OTN.pdf*.

Chapter 11 of the *Medicare Benefit Policy Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9609
Related Change Request (CR) #: CR 9609
Effective Date: January 1, April 1, or July 1, 2017 as noted.
Related CR Release Date: September 16, 2016
Related CR Transmittal #: R1715OTN
Implementation Date: January 3, April 3, or July 3, 2017

Overview of the skilled nursing facility value-based purchasing program

Provider types affected

This article is intended for physicians, clinical staff, and administrators of skilled nursing facilities (SNFs) submitting claims under the SNF prospective payment system (PPS) to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries during a SNF stay.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) SNF value-based purchasing (VBP) program is one of many VBP programs that aims to reward quality and improve health care. Beginning October 1, 2018, SNFs will have an opportunity to receive incentive payments based on performance on the specified quality measure.

Background

The Protecting Access to Medicare Act (PAMA) of 2014, enacted into law on April 1, 2014, authorized the SNF VBP program. PAMA requires CMS to adopt a VBP payment adjustment for SNFs beginning October 1, 2018. By law, the SNF VBP program is limited to a single readmission measure at a time.

PAMA requires CMS, among other things, to:

- Furnish value-based incentive payments to SNFs for services beginning October 1, 2018.
- Develop a methodology for assessing performance scores.
- Adopt performance standards on a quality measure that include achievement and improvement.

Rank SNFs based on their performance from low to high. The highest ranked facilities will receive the highest payments, and the lowest ranked 40 percent of facilities will receive payments that are less than what they otherwise would have received without the program.

CMS will withhold 2 percent of SNF Medicare payments starting October 1, 2018, to fund the incentive payment pool and will then redistribute 50-70 percent of the withheld payments back to SNFs through the SNF VBP program.

Readmissions Measures

Skilled Nursing Facility 30-Day All Cause Readmission Measure (SNFRM)

In the *Fiscal Year (FY) 2016 SNF Prospective Payment System (PPS) final rule*, CMS adopted the SNFRM as the first measure for the SNF VBP Program. The measure is defined as the risk-standardized rate of all-cause, unplanned hospital readmissions of Medicare beneficiaries within 30 days of discharge from their prior hospitalization. Hospital readmissions are identified through Medicare hospital claims (not SNF claims) so no readmission data is collected from SNFs and there are no additional reporting requirements for the measure. This measure is endorsed by the National Quality Forum.

Readmissions to a hospital within the 30-day window are counted regardless of whether the beneficiary is readmitted directly from the SNF or after discharge from the SNF as long as the beneficiary was admitted to the SNF within 1 day of discharge from a hospital stay. The measure excludes planned readmissions because they do not indicate poor quality of care. The measure is risk-adjusted based on patient demographics, principal diagnosis from the prior hospitalization, comorbidities, and other health status variables that affect probability of readmission.

Other exclusions include patients who were hospitalized for medical treatment of cancer, do not have Medicare Part A coverage for the full 30-day window, and do not have Part A coverage for the 12 months preceding the prior hospital discharge. Additional exclusions include SNF stays with:

- An intervening post-acute care admission within the 30-day window,
- Patient discharge from the SNF against medical advice,
- Principal diagnosis in prior hospitalization was for rehabilitation, fitting of prosthetics,
- or adjustment of devices,
- Prior hospitalization for pregnancy, and
- Other reasons documented in the measure's technical specifications.

SNF 30-day potentially preventable readmission (SNFPPR) measure

On July 29, 2016, CMS adopted the SNFPPR measure for future use in the SNF VBP program. The SNFPPR measure assesses the risk-standardized rate of unplanned, potentially preventable readmissions (PPRs) for Medicare fee-for-service SNF patients within 30 days of discharge from a prior hospitalization.

Potentially preventable hospital readmissions for post-acute care are defined using the existing evidence, empirical analysis, and technical expert panel input. However, the key difference between the SNFRM and SNFPPR measures is that the SNFPPR focuses **on potentially preventable readmissions** rather than **all-cause** readmissions. As required by the program's statute, CMS will replace the SNFRM with the SNFPPR as soon as practicable.

Performance scoring

CMS has adopted these scoring methodologies to measure SNF performance that includes levels of achievement and improvement:

- **Achievement scoring** compares a SNF's performance rate in a performance period against all SNFs' performance during the baseline period

See **VALUE**, next page

2017 update of HCPCS codes for SNF consolidated billing

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs and durable medical equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

Stop – impact to you

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in change request (CR) 9735 could impact your payments.

Caution – what you need to know

CR 9735 provides the 2017 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF CB) and explains how the updates affect edits in Medicare claim processing systems. By the first week in December 2016, the new code files for Part B processing, and the new Excel and PDF files for Part A processing, will be available at *https://www.cms.gov/SNFConsolidatedBilling* and will become effective on January 1, 2017.

Go – what you need to do

The provider community should read the "General Explanation of the Major Categories" PDF file located at the bottom of each year's MAC update in order to understand the major categories, including additional exclusions not driven by HCPCS codes.

Background

The common working file (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid.

Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the Chapter 6, Section 20.6 (Part A) and Section 110.4.1 (Part B) of the *Medicare Claims Processing Manual*, available for download at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf*.

Additional information

The official instruction, CR 9735, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3603CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9735
Related Change Request (CR) #: CR 9735
Related CR Release Date: August 26, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3603CP
Implementation Date: January 3, 2017

VALUE

From previous page

- **Improvement scoring** compares a SNF's performance during the performance period against its own prior performance during the baseline period

For FY 2019 of the SNF VBP program, achievement scoring will compare SNFs' 2017 performance to the performance of all facilities during 2015. Improvement scoring methodology will compare a SNFs' 2017 performance to its own performance during 2015. For more information about the SNF VBP program's scoring methodology, refer to the *FY 2017 SNF PPS final rule*.

Quality feedback reports

On October 1, 2016, SNFs will begin receiving quarterly confidential feedback reports about their performance in the SNF VBP program via the certification and survey provider enhanced reporting (CASPER) system.

Additional information

For more information about the SNF VBP program, visit *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html* and refer to the FY 2016 SNF PPS final rule and the FY 2017 SNF PPS final rule.

If you have additional questions, please email them to: *SNFVBPinquiries@cms.hhs.gov*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: SE1621
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Internet-only manual updates to correct errors and omissions

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9748 revises the following Medicare manuals to correct various minor technical errors and omissions:

- *Medicare General Information, Eligibility, and Entitlement Manual*
- *Medicare Benefit Policy Manual*
- *Medicare Claims Processing Manual*

The revisions of these manuals are intended to clarify the existing content, and no policy, processing, or system changes are anticipated.

Key points of CR 9748

CR 9748 includes all revisions as attachments, and selected extracts from these attachments are as follows:

***Medicare General Information, Eligibility, and Entitlement Manual* revision summary**

- Chapters 4 and 5 of this manual are revised to include references to another manual with related information and a reference to a related regulation.

***Medicare Benefit Policy Manual* summary of key revisions**

- In several sections, references to related material in other manuals are included.
- Language is added to refer providers to a list of exclusions from consolidated billing (CB, the SNF "bundling" requirement), which is available at *https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*.
- Language is added to state that "Medicare's post-hospital extended care benefit is not designed to provide broad coverage in SNFs of what is commonly regarded as "nursing home" care; that is, long-term, relatively low-level assistance with activities of daily living (see Chapter 16, Section 110 of the *Medicare Benefit Policy Manual* for a discussion of Medicare's general coverage exclusion of "custodial" care). Rather, Congress originally enacted this benefit in order to achieve savings in Medicare expenditures on inpatient hospital stays, by creating a less expensive institutional substitute for what would otherwise be the final, convalescent portion of the hospital stay itself. Accordingly, the post-hospital extended care benefit focuses specifically on care that serves as a fairly brief and highly skilled "extension" of a beneficiary's inpatient hospital stay. In this context, the three-day qualifying hospital stay requirement serves to target more effectively the limited population that this benefit was originally created to cover: specifically, those beneficiaries who require a relatively intensive but also fairly brief course of SNF care as a continuation of their inpatient hospital stay."

***Medicare Claims Processing Manual* key revision summary**

- In several sections, references to related material in other manuals are included.

Additional information

The official instruction, CR 9748, issued to your MAC regarding this change is available via three transmittals:

- The first updates the *Medicare General Information, Eligibility, and Entitlement Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R101GI.pdf*.
- The second transmittal updates the *Medicare Benefit Policy Manual* is at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R227BP.pdf*.
- The thirds updates the *Medicare Claims Processing Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3612CP.pdf*.

MLN Matters® Number: MM9748
Related Change Request (CR) #: CR 9748
Related CR Release Date: September 16, 2016
Effective Date: October 18, 2016
Related CR Transmittal #: R101GI, R227BP, and R3612CP
Implementation Date: October 18, 2016

October healthcare provider taxonomy code set update

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health and hospice MACs, and durable medical equipment MACs, for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9659 instructs MACs to obtain the most recent healthcare provider taxonomy code (HPTC) set and to update their internal HPTC tables and/or reference file. MACs that have the capability to do so will implement the October 2016 HPTC set as early as October 1, 2016, for claims received on or after October 1, 2016. All MACs will implement the HPTC set by January 3, 2017.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including healthcare claims.

The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use.
2. Terminated codes are not approved for use after a specific date.
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR 9659 implements the NUCC HPTC code set that is effective on October 1, 2016, and instructs MACs to obtain the most recent HPTC set at *http://www.wpc-edi.com/codes* and use it to update their internal HPTC tables and/or reference files.

When reviewing the HPTC code set online, you can identify revisions made since the last release by the color code:

- New items are green
- Modified items are orange, and
- Inactive items are red

Additional information

The official instruction, CR 9659, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3597CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9659
Related Change Request (CR) #: CR 9659
Related CR Release Date: August 26, 2016
Effective Date: October 1, 2016
Implementation Date: January 3, 2017, except some MACs may implement on October 1, 2016
Related CR Transmittal #: R3597CP

Take action to combat the flu

Now is the perfect time for providers to vaccinate Medicare beneficiaries, as it can take two weeks after vaccination to develop antibodies that protect against seasonal influenza. As a health care provider, you play an important role in setting an example by getting yourself vaccinated and recommending and promoting influenza vaccination.

Claim status category and claim status codes update

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including durable medical equipment (DME) MACs, and home health & hospice (HH&H) MACs for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9680 updates, as needed, the claim status and claim status category codes used for the Accredited Standards Committee (ASC) x12 276/277 health care claim status request and response and ASC x12xd 277 health care claim acknowledgement transactions.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the ASC x12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC x12 276.277 transactions to report claim status.

The National Code Maintenance Committee (NCMC) meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The NCMC allows the industry six months for implementation of newly added or changed codes. Codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claimstatus-category-codes/* and *http://www.wpcedi.com/reference/codelists/healthcare/claim-status-codes/*. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the September/October 2016 committee meeting shall be posted on these sites on or about November 1, 2016. MACs will complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes, by the implementation of CR 9680.

These code changes are to be used in editing of all ASC x12 276 transactions processed on or after the date of implementation and to be reflected in the ASC x12 277 transactions issued on and after the date CR 9680 is implemented.

MACs must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC x12 276/277 health care claim status request and response. The MACs must use valid claim status category codes and claim status codes when sending ASC x12 277 health care claim status responses. They must also use valid claim status category codes and claim status codes when sending ASC x12 277 health care claim acknowledgments.

References in this CR to "277 responses" and "claim status responses" encompass both the ASC x12 277 health care claim status response and the ASC x12 277 healthcare claim acknowledgment transactions.

Additional information

The official instruction, CR 9680, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3599CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

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Related CR Release Date: August 26, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3599CP
Implementation Date: January 3, 2017

Implement operating rules - phase III ERA EFT: CORE 360 uniform use of claim CARC, RARC, and CAGC rule - update from CAQH CORE

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including durable medical equipment (DME) MACs and home health & hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9766 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) committee on operating rules for information exchange (CORE) defined code combinations per operating rule 360 - uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE EFT & ERA operating rule set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CR 9766 deals with the regular update in CAQH CORE defined code combinations per operating rule 360 - uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule.

CAQH CORE will publish the next version of the code combination list on or about October 1, 2016. This update is based on the claim adjustment reason code (CARC), remittance advice remark code (RARC) updates as posted at the WPC website on or about July 1, 2016. This will also include updates based on market based review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare as the industry needs them.

See *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

Note: Per ACA mandate all health plans including Medicare must comply with CORE 360 uniform use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE-defined business scenarios. With the four CORE-defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 9766, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3600CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

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Related CR Release Date: August 26, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3600CP
Implementation Date: January 3, 2017

Requirements for phase II and phase III compliance for batch processing – operating rules

Provider types affected

This *MLN Matters*® article is intended for physicians and providers submitting claims to Medicare administrative contractors (MACs), including home health and hospice MACs, for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9358 requires MACs to meet the connectivity and security requirements for the phases II and III council for Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules (CORE) operating rules as well as the batch processing requirements for the phase II CAQH CORE operating rules.

Background

The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing operating rules adopted under Section 1104 of the Affordable Care Act. The Secretary of the Department of Health & Human Services (HHS) named the CAQH CORE as the authoring entity of the phase I, II, and III operating rule. The operating rules are intended to provide additional direction and clarification to the electronic data interchange (EDI) standard adopted under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. CMS is currently in the process of implementing the batch requirements for the phase II rules for the claim status inquiry and response as well as the phase III rules for the electronic remittance advice (ERA) and electronic funds transfer (EFT).

HIPAA transactions are referred to in the following manner:

- 276: ASC X12 health care claim status request
- 277: ASC X12 health care information status notification
- 835: ASC X12 health care claim payment/advice
- 999: ASC X12 implementation acknowledgment for health care insurance

CR 9358 requires the MACs to implement a solution to comply with CAQH CORE phase II connectivity rule 270, including the use of X.509 client certificates over SSL. This solution must be able to receive and post the batch 276/277 transactions for using the public internet for the hypertext transfer protocol within a connection encrypted by transport layer security (HTTP/S) transport. The MACs shall accept 276 transactions up until 9:00 p.m. of a business day, which equates to receipt of the 276 within the EDI front-end system for any 276 transactions submitted via either the MAC's electronic data interchange (EDI) gateway or the public internet. The MAC must then return the 277 transaction by 7:00 a.m. the next business day. The MACs must also track the times of any received inbound messages with the capability to generate a report (audit log) that tracks the 999 response to the inbound 276 as well as date and timestamp for the 277, including the date and time the message was sent in HTTP+MIME or SOAP+WSDL message header tags. The MACs must support both message envelope standards and message exchanges (HTTP+MIME) and simple object access protocol and web service definition language (SOAP+WSDL) message. The solution must be able to report HTTP server errors with an HTTP 500 internal service error or a HTTP 503 service unavailable error message for 276/277/835/999 transactions. The MACs must support submitter authentication standards as detailed in operating rule 153 for the 276/277/835/999 transactions.

The MACs will also develop and implement a solution using HTTP/S version 1.1 over the public internet as a transport method for the 835 in accordance with the phase III infrastructure rule 350, which requires entities to support the phase II CORE 270 connectivity rule version 2.2.0. If a trading partner decides to transition to exchanging files over the public internet, and the MAC's environment does not permit for dual submission/retrieval using CORE and non-CORE connectivity, there will not be a transition period, just a scheduled flash cut. If the MAC's environment has the ability to support the use of either gateway or public internet, the MACs shall have discretion to make the business decision on transition and ability to switch between connectivity options.

MACs will make updates to their enrollment procedures, forms and trading partner management system for connectivity over the public internet. Enrollment in the internet needs to be at the trading partner level.

Additional information

The official instruction, CR 9358, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1716OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

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Related CR Release Date: September 16, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R1716OTN
Implementation Date: April 3, 2017

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Table 1 – New separately payable procedure code, effective October 1, 2016

Code	Dscriptor		SI	APC	Effective date
	Short	Long			
C9744	Abd us w/ contrast	Ultrasound, abdominal, with contrast	S	5571	10/1/16

Smoking cessation codes

Effective September 30, 2016, HCPCS codes G0436 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and G0437

(Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) are deleted. The services previously represented by HCPCS codes G0436 and G0437 should be billed under existing CPT® codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) respectively. See Table 2.

Table 2 – Deleted smoking cessation codes and the existing replacement CPT® codes

Deleted code	Long description	Add date	Term date	Existing replace-ment code
G0436	Smoking and tobacco use cessation counseling visit;	1/1/08	9/30/16	99406
G0437	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	1/1/08	9/30/16	99407

Reporting for certain outpatient department services (that are similar to therapy services) (“non-therapy outpatient department services”) that are adjunctive to comprehensive APC procedures

Non-therapy outpatient department services are services such as physical therapy, occupational therapy, and speech-language pathology provided during the perioperative period (of a comprehensive APC (C-APC) procedure) without a certified therapy plan of care. These are not therapy services as described in Section 1834(k) of the Social Security Act (the Act), regardless of whether the services are delivered by therapists or other nontherapist health care workers. Therapy services are those provided by therapists under a plan of care in accordance with Section 1835(a)(2)(C) and Section 1835(a)(2)(D) of the Act and are paid for under Section 1834(k) of the Act, subject to annual therapy caps as applicable (78 FR 74867 and 79 FR 66800). Because these services are outpatient department services and not therapy services, the requirement for functional reporting under the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) does not apply.

The comprehensive APC payment policy packages payment for adjunctive items, services, and procedures into the most costly primary procedures under the OPPS at the claim level. When non-therapy outpatient department services are included on the same claim as a C-APC procedure (status indicator (SI) = J1) (see 80 FR 70326) or the specific combination of services assigned to the observation comprehensive APC 8011 (SI = J2), these services are considered adjunctive to the primary procedure. Payment for non-therapy outpatient department services is included as a packaged part of the payment for the C-APC procedure.

Effective for claims received on or after October 1, 2016, with dates of service on or after January 1, 2015, providers may report non-therapy outpatient department services (that are similar to therapy services) that are adjunctive to a C-APC procedure (SI = J1) or the specific combination of services assigned to the observation comprehensive APC 8011 (SI = J2), in one of two ways:

1. Without using the therapy CPT® codes and instead reporting these non-therapy services with revenue code 0940 (other therapeutic services); or
2. Reporting non-therapy outpatient department services that are adjunctive to J1 or J2 services with the appropriate occurrence codes, CPT® codes, modifiers, revenue codes, and functional reporting requirements.

Advanced care planning (ACP)

Effective January 1, 2016, payment for the service described by CPT® code 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) is conditionally packaged under the OPPS and is consequently assigned to a conditionally packaged payment status indicator of “Q1.” When this service is furnished with another service paid under the OPPS, payment is packaged; when it is the only service furnished, payment is made separately. CPT® code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)) is an add-on code and

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therefore payment for the service described by this code is unconditionally packaged (assigned status indicator ‘‘N’’) in the OPPS in accordance with 42 CFR 419.2(b)(18).

Drugs, biologicals, and radiopharmaceuticals

Drugs and biologicals with payments based on average sales price (ASP), effective October 1, 2016

Payment for separately payable nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals (status indicator “K”) is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals (status indicator “G”) is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective October 1, 2016, and drug price restatements are available in the October 2016 update of the OPPS Addendum A and Addendum B at *https://www.cms.gov/HospitalOutpatientPPS/*.

Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals paid based on the ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*.

Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

Drugs and biologicals with OPPS pass-through status, effective October 1, 2016

Four drugs and biologicals have been granted OPPS pass-through status effective October 1, 2016. These items, along with their descriptors and APC assignments, are shown in Table 3.

Table 3 – Drugs and biologicals with OPPS pass-through status, effective October 1, 2016

HCPCS	Long descriptor	SI	APC
C9139	Injection, Factor IX, albumin fusion protein (recombinant), Idelvion, 1 i.u.	G	9171
C9481	Injection, reslizumab, 1 mg	G	9481
C9482	Injection, sotalol hydrochloride, 1 mg	G	9482
C9483	Injection, atezolizumab, 10 mg	G	9483

Revised status indicator for biosimilar biological product

On April 5, 2016, a biosimilar biological product, Inflectra®, was approved by the Food and Drug Administration (FDA).

Due to the unavailability of pricing information, Inflectra®, described by code Q5102 (Injection, infliximab, biosimilar, 10 mg), is assigned SI= E (Not paid under OPPS or any other Medicare payment system.) Inflectra® was previously assigned SI= K (Separately paid nonpass-through drugs and biologicals, including therapeutic radiopharmaceuticals) in the July 2016 update of the OPPS. This change is effective July 1, 2016.

Table 4 lists the code and the effective date for the status indicator change.

Table 4 – Drugs and biologicals with revised status indicators

HCPCS code	Long descriptor	OPPS SI	Effective date
Q5102	Injection, Infliximab, Biosimilar, 10 mg	E	7/1/16

Billing guidance for the topical application of mitomycin during or following ophthalmic surgery

Hospital outpatient departments should only bill HCPCS code J7315 (Mitomycin, ophthalmic, 0.2 mg) or HCPCS code J7999 (Compounded drug, not otherwise classified) for the topical application of mitomycin during or following ophthalmic surgery. J7315 may be reported only if the hospital uses mitomycin with the trade name Mitosol®. Any other topical mitomycin should be reported with J7999. Hospital outpatient departments are not permitted to bill HCPCS code J9280 (Injection, mitomycin, 5 mg) for the topical application of mitomycin.

Changes to OPPS pricer logic

ASP fee amounts moves from the OPPS pricer to the fiscal intermediary shared system (FISS)

OPPS drug pricing will now apply the ASP fee schedule amounts from the FISS standard system and not the OPPS pricer. OPPS covered drugs with allowed payment

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amounts will continue to have status indicators “G” and “K” applied. Drugs that are listed as packaged under OPPS will continue to be packaged with this change of payment application systems.

Outpatient coinsurance cap logic as ASP payment for drugs moves from the OPPS pricer to the FISS

Outpatient procedure coinsurance is capped to the inpatient deductible limit (IP Limit). The cap is calculated by adding the highest wage adjusted national coinsurance amount for the procedure line (identified by status indicators S, T, V, P, J1 or J2) plus the coinsurance for the blood products (identified by status indicator “R”) and comparing to the inpatient Part A deductible. The difference is the amount of coinsurance to be applied to the ASP drug lines. The coinsurance of the ASP drug lines with the same dates of service as the procedure code are added together. The coinsurance reduction percentage is calculated by dividing the amount of coinsurance to be applied to the ASP drug lines by the total coinsurance of the ASP drug lines. The coinsurance amount for each of ASP drug lines should be reduced by the multiplication of the drug line coinsurance and the coinsurance reduction percentage. The difference between the original coinsurance and the reduced coinsurance is then added to the payment. CMS’ shared system will cap the coinsurance for the drugs with status indicator G or K (except for pass-through drugs with a payment adjustment flags (PAF) 10, or 18-20 [indicating no coinsurance applies]) that was not assigned to the IP Limit for the calendar year. Several claim examples are as follows:

Example 1 of inpatient deductible capped amount:

Drug line A has a fee of $2,000.00, a payment of $1,600.00, and coinsurance of $400.00.

Drug line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.

Drug line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Drug line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $888.00.

The inpatient Part A deductible is $1,288.00 for 2016.

$1,288.00 - $888.00 = $400.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug lines A-D coinsurance is $800.00.

$400.00 cap remaining / $800.00 drug line(s) coinsurance = 50 percent reduction to coinsurance due to inpatient deductible cap

Apply 50 percent reduction of the coinsurance amounts for each line and add the remaining 50 percent back into the payment amount.

Drug line A has a final payment of $1,800.00, and coinsurance of $200.00.

Drug line B has a final payment of $900.00, and coinsurance of $100.00.

Drug line C has a final payment of $450.00, and coinsurance of $50.00.

Drug line D has a final payment of $450.00, and coinsurance of $50.00.

Example 2 of inpatient deductible capped amount:

Drug line A has a fee of $2,000.00, a payment of $1,600.00, and coinsurance of $400.00.

Drug line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.

Drug line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Drug line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $1,588.00.

The inpatient Part A deductible is $1,288.00 for 2016.

$1,588.00 is greater than $1,288.00. The OPPS Pricer will cap the coinsurance amount to be applied on the highest wage adjusted national coinsurance procedure line prior to application of the cap on the drug lines.

Drug lines A-D coinsurance is $800.00.

$0 cap remaining / $800.00 = 100 percent reduction to coinsurance due to inpatient deductible cap

Drug line A has a final payment of $2,000.00, and no coinsurance.

Drug line B has a final payment of $1,000.00, and no coinsurance.

Drug line C has a final payment of $500.00, and no coinsurance.

Drug line D has a final payment of $500.00, and no coinsurance.

Example 3 of inpatient deductible capped amount with procedure, blood, and drug lines:

Drug line A has a fee of $2,000.00, a payment of $1,600.00, and coinsurance of $400.00.

Drug line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.

Drug line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Drug line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $800.00.

Coinsurance on blood line is 88.00.

The inpatient Part A deductible is $1,288.00 for 2016.

$1,288.00 - $888.00 = $400.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug lines A-D coinsurance is $800.00.

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$400.00 cap remaining / $800.00 drug line(s) coinsurance = 50 percent reduction to coinsurance due to inpatient deductible cap

Apply 50 percent reduction of the coinsurance amounts for each line and add the remaining 50 percent back into the payment amount.

Drug line A has a final payment of $1,800.00, and coinsurance of $200.00.

Drug line B has a final payment of $900.00, and coinsurance of $100.00.

Drug line C has a final payment of $450.00, and coinsurance of $50.00.

Drug line D has a final payment of $450.00, and coinsurance of $50.00.

Example 4 of inpatient deductible capped amount equals procedure, blood, and drug line coinsurance:

Drug line A has a fee of $200.00, a payment of $160.00, and coinsurance of $40.00.

Drug line B has a fee of $100.00, a payment of $80.00, and coinsurance of $20.00.

Drug line C has a fee of $50.00, a payment of $40.00 and coinsurance of $10.00.

Drug line D has a fee of $50.00, a payment of $40.00 and coinsurance of $10.00.

Highest wage adjusted national coinsurance amount for a procedure line is $1,120.00.

Coinsurance on blood line is 88.00.

The inpatient Part A deductible is $1,288.00 for 2016.

$1,288.00 - $1208.00 = $80.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug lines A-D coinsurance is $80.00.

$80.00 cap remaining - $80.00 drug line(s) coinsurance = reduction to coinsurance due to inpatient deductible cap does not apply

Drug line A has a fee of $200.00, a payment of $160.00, and coinsurance of $40.00.

Drug line B has a fee of $100.00, a payment of $80.00, and coinsurance of $20.00.

Drug line C has a fee of $50.00, a payment of $40.00 and coinsurance of $10.00.

Drug line D has a fee of $50.00, a payment of $40.00 and coinsurance of $10.00.

Example 5 of procedure and blood coinsurance equal inpatient deductible cap:

Drug line A has a fee of $2,000.00, a payment of $1,600.00, and coinsurance of $400.00.

Drug line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.

Drug line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Drug line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $1200.00.

Coinsurance on blood line is 88.00.

The inpatient Part A deductible is $1,288.00 for 2016.

$1,288.00 - $1,288.00 = $0.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug lines A-D coinsurance is $800.00.

$0.00 cap remaining / $800.00 drug line(s) coinsurance = 100 percent reduction to coinsurance due to inpatient deductible cap.

Apply 100 percent reduction of the coinsurance amounts for each line and add the remaining 100 percent back into the payment amount.

Drug line A has a final payment of $2,000.00, and coinsurance of $0.00.

Drug line B has a final payment of $1,000.00, and coinsurance of $0.00.

Drug line C has a final payment of $500.00, and coinsurance of $0.00.

Drug line D has a final payment of $500.00, and coinsurance of $0.00.

Example 6 of part B deductible applies to drug charges prior to inpatient deductible capped amount:

Drug line A has a fee of $2,166.00, a deductible of $166.00, a payment of $1,600.00, and coinsurance of $400.00.

Drug line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.

Drug line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Drug line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $888.00.

The inpatient Part A deductible is $1,288.00 for 2016.

$1,288.00 - $888.00 = $400.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug lines A-D coinsurance is $800.00.

$400.00 cap remaining / $800.00 drug line(s) coinsurance = 50 percent reduction to coinsurance due to inpatient deductible cap.

Apply 50 percent reduction of the coinsurance amounts for each line and add the remaining 50 percent back into the payment amount.

Drug line A has a deductible of $166.00, a final payment of $1,800.00, and coinsurance of $200.00.

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Drug line B has a final payment of $900.00, and coinsurance of $100.00.

Drug line C has a final payment of $450.00, and coinsurance of $50.00.

Drug line D has a final payment of $450.00, and coinsurance of $50.00.

Pass-through drug offset moves from the OPPS pricer to the FISS shared system

Outpatient pass-through drugs with offsets will be identified by the I/OCE payer only value codes (QR, QS, and QT) when appropriate pairings are found on the claim. Offsets will continue to be wage-adjusted prior to application and will apply to the drug line(s) payment amount. Pass-through drugs with are eligible for an offset continue to not have coinsurance applied whether the off-set is made or not.

Coverage determinations

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

MACs will adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of October 2016 OPPS pricer.

Additional information

The official instruction, CR 9768, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3602CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9768
Related Change Request (CR) #: CR 9768
Related CR Release Date: August 26, 2019
Effective Date: October 1, 2016
Related CR Transmittal #: R3602CP
Implementation Date: October 3, 2016

New procedure code G0498 for external pump

Effective for claims processed on or after October 3, 2016, with dates of service on or after January 1, 2016, a new HCPCS code G0498 (Short descriptor: chemo extend iv infusion w/ pump) is being implemented for use when billing prolonged drug and biological infusions started incident to a physician service using an external pump. Please see the long descriptor of the code below. For complete information please see change request (CR) 9749 (October update to the 2016 Medicare physician fee schedule database).

In a recent article, First Coast provided temporary instructions to providers on how to submit claims for both Medicare Part A (outpatient hospital) and Medicare Part B, for the external pump. The instructions were published as a result of *MLN Matters® SE1609*.

With the implementation of the new code G0498, it is no longer necessary to follow the previous instructions. All claims for the use of an external pump, billed to the MACs will be processed via the normal claim processing guidelines. Additionally, providers should continue to bill for the drugs/biologicals and the administration as these services do not include reimbursement for the pump. HCPCS code G0498 is billed only once per episode of care using the initiation of treatment as the date of service. HCPCS code G0498 will include payment for CPT® 96416 (Initiation of prolonged chemotherapy infusion more than 8 hours) when billed on the same day; separate payment will not be allowed for CPT® 96416.

In order for Medicare to pay for a drug or biological under Section 1861(s)(2)(A) or (B) of the Act, the physician or hospital (respectively) must incur a cost for the drug or biological. Generally, the administration of drugs or biologicals covered by Medicare under the "incident to" benefit (1861(s)(2)(A) and (B)) will start and end while the patient is in the physician's office or the hospital outpatient department under the supervision of a physician.

However, in some situations a hospital or office may purchase a drug for a medically reasonable and necessary prolonged drug infusion, then begin the drug infusion in the care setting using an external pump, send the patient home for a portion of the infusion duration, and have the patient return at the end of the infusion period. In this case, the drug or biological continues to be covered under Section 1861(s)(2)(A) and (B) of the Act and is billable to the A/B Medicare administrative contractor even though the entire administration of the drug or biological did not occur in the physician's office or the hospital outpatient department.

October update to the Medicare physician fee schedule database

***Note**: This article was revised August 24, 2016, due to a revised change request (CR). The transmittal number, CR release date and link to the CR also changed. All other information remains unchanged. This information was previously published in the August 2016 Medicare A Connection, page 16.*

Provider types affected

This *MLN Matters*® article is intended for physicians, provider and suppliers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries and subject to the Medicare physician fee schedule (MPFS).

Provider action needed

This article is based on CR 9749, which informs you that payment files were issued to MACs based upon the MPFS final rule. This change request amends those payment files. Make sure that your billing staffs are aware of these changes.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. Unless otherwise stated, the changes included in the October update to the 2016 MPFSDB are effective for dates of service on and after January 1, 2016.

The key changes for the October update are the following:

Code	Action
G0436	Procedure status = I (Effective for services on or after 10-1-2016.)
G0437	Procedure status = I (Effective for services on or after 10-1-2016.)
44799	Procedure status = C; global surgery days = YYY
32666	Bilateral indicator = 1

The HCPCS codes listed below have been added to the MPFSDB effective for dates of service on and after October 1, 2016. All of these new codes were communicated through other instructions. Please consult those instructions for the description and other information.

Code	Action
G0490	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9679	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9680	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9681	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9682	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9683	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9684	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9685	Procedure status = A; RVUs = work 3.86, non-facility 1.55, facility 1.55, MP 0.29
G9686	Procedure status = A; RVUs = work 1.50, non-facility 0.61, facility 0.61, MP 0.10

The following payment policy indicators apply to G9685 and G9686: multiple surgery = 0, bilateral surgery = 0, assistant at surgery = 0, co-surgeons = 0, team surgeons = 0, PC/TC = 0, physician supervision of diagnostic procedures = 09, and diagnostic imaging family = 99. The global surgery days = XXX.

New code G0498, listed below, has been added to the MPFSDB effective for dates of service on and after January 1, 2016. The procedure status is C and there are no RVUs. The following payment policy indicators apply to G0498: multiple surgery = 0, bilateral surgery = 0, assistant at surgery = 0, co-surgeons = 0, team surgeons = 0, PC/TC = 5, physician supervision of diagnostic procedures = 09, and diagnostic imaging family = 99. The global surgery days = YYY.

Code	Short descriptor	Long descriptor
G0498	Chemo extend iv infus w/ pump	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/other outpatient setting using office/other outpatient setting pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/other outpatient setting, includes follow up office/ other outpatient visit at the conclusion of the infusion

Additional information

The official instruction, CR 9749, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R3595CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork-MLN/MLNMattersArticles/index.html*.

See MPFSDB, next page

October update for 2016 DMEPOS fee schedule

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

What you need to know

Change request (CR) 9756 advises providers of fee schedule amounts for codes in effect on October 1, 2016. Make sure your billing staffs are aware of these updates.

Key points

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural fee schedule amounts. ZIP codes for non-continental metropolitan statistical areas (MSA) are not included in the DMEPOS rural ZIP code file. The DMEPOS rural ZIP code file is updated on a quarterly basis as necessary.

October quarterly updates are only required for the DMEPOS rural ZIP code file fourth quarter rural ZIP code changes for 2016. MACs will process claims for DMEPOS items using the rural ZIP code file for dates of service on or after October 1, 2016.

The October 2016 DMEPOS rural ZIP code public use file (PUF), containing the rural ZIP codes effective for fourth quarter rural ZIP code changes for 2016, will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/* for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the above PUF.

Additional information

The official instruction, CR 9756, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3598CP.pdf*.

Chapter 23 of the *Medicare Claims Processing Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9756
Related Change Request (CR) #: CR 9756
Related CR Release Date: August 26, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3598CP
Implementation: October 3, 2016

DMEPOS fee schedule: Corrections to the July 2016 file

On June 23, 2016, the Centers for Medicare & Medicaid Services released the July 2016 Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule amounts. CMS identified errors in the fee schedule amounts for some items and released revised fee schedule files August 31, 2016. Check the DME Center Page (*http://go.usa.gov/xDYr9*) for more information.

MPFSDB

From previous page

Document history

Date of change	Description
August 24, 2016	**Note**: The article was revised due to a revised change request (CR), The transmittal number, CR release date and link to the CR also changed.
August 19, 2016	Initial article released

MLN Matters® Number: MM9749 *Revised*
Related Change Request (CR) #: CR 9749
Related CR Release Date: August 24, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3595CP
Implementation Date: October 3, 2016

2017 annual update for the health professional shortage area bonus payments

Provider types affected

This *MLN Matters*® article is intended for physicians submitting claims to Medicare administrative contractors (MACs) for services provided in health professional shortage area (HPSAs) to Medicare beneficiaries.

Provider action needed

Change request (CR) 9781 alerts you that the annual HPSA bonus payment file for 2017 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your MAC and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2017, through December 31, 2017. You should review physician bonuses web page at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses* each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

Background

Section 413(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. CMS automated HPSA ZIP code file shall be populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file shall be made available to contractors in early December of each year. MACs will implement the HPSA ZIP code file and for claims with dates of service January 1 to December 31 of the following year, shall make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

Additional information

The official instruction, CR 9781, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3610CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9781
Related Change Request (CR) #: CR 9781
Related CR Release Date: September 9, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3610CP
Implementation Date: January 3, 2017

Annual clotting factor furnishing fee update 2017

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers billing Medicare administrative contractors (MACs) for services related to the administration of clotting factors provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9759 updates the clotting factor furnishing fee for 2017, and announces that for 2017 it is $0.209 per unit. Make sure that your billing staffs are aware of this update to the annual clotting factor furnishing fee for 2017.

Background

The Centers for Medicare and Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. The clotting factor furnishing fee is updated each calendar year based on the percentage increase in the consumer price index (CPI) for medical care for the 12-month period ending with June of the previous year.

Effective for dates of service from January 1, 2017, through December 31, 2017, the clotting factor furnishing fee of $0.209 per unit is included in the published payment limit for clotting factors, and it will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the average sale price (ASP) Medicare Part B drug pricing file or the not otherwise classified (NOC) pricing file.

Additional information

The official instruction, CR 9759, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3607CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9759
Related Change Request (CR) #: CR 9759
Related CR Release Date: August 26, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3607CP
Implementation Date: January 3, 2017

Influenza vaccine payment allowances - annual update for 2016-2017 season

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers submitting claims to Medicare administrative contractors (MACs) for influenza vaccines provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9758 informs MACs about the payment allowances for seasonal influenza virus vaccines. These payment allowances are updated on August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved after the release of CR 9758 at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*. Make sure that your billing staffs are aware that the payment allowances are being updated.

Background

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the average wholesale price (AWP) as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). In these instances, payment for the vaccine is based on reasonable cost

The Medicare Part B payment allowances for the following *Current Procedural Terminology* (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2016-July 31, 2017:

- CPT® 90653 Payment allowance is pending
- CPT® 90655 Payment allowance is pending
- CPT® 90656 Payment allowance is pending
- CPT® 90657 Payment allowance is pending
- CPT® 90661 Payment allowance is pending
- CPT® 90685 Payment allowance is pending
- CPT® 90686 Payment allowance is pending
- CPT® 90687 Payment allowance is pending
- CPT® 90688 Payment allowance is pending
- HCPCS Q2035 Payment allowance is pending
- HCPCS Q2036 Payment allowance is pending
- HCPCS Q2037 Payment allowance is pending
- HCPCS Q2038 Payment allowance is pending

Payment for the following CPT®/HCPCS codes may be made if your MAC determines their use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2016-July 31, 2017:

- CPT® 90630 Payment allowance is pending
- CPT® 90654 Payment allowance is pending
- CPT® 90662 Payment allowance is pending
- CPT® 90672 Payment allowance is pending
- CPT® 90673 Payment allowance is pending
- CPT® 90674 Payment allowance is pending
- HCPCS Q2039 Flu vaccine adult - not otherwise classified payment allowance is to be determined by your MAC with effective dates of August 1, 2016-July 31, 2017

The Centers for Medicare & Medicaid Services (CMS) will publish the approved payment allowances on the *CMS seasonal influenza vaccines pricing* web page after CR 9758 is released and as the information becomes available. Please note that the effective dates for these vaccines will be the date of FDA approval.

Providers should note that:

- All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- The annual Part B deductible and coinsurance amounts do not apply.
- While your MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims, they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 9758, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3611CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*.

MLN Matters® Number: MM9758
Related Change Request (CR) #: CR 9758
Related CR Release Date: September 9, 2016
Effective Date: August 1, 2016
Related CR Transmittal #: R3611CP
Implementation Date: No later than November 1, 2016

Upcoming provider outreach and educational events

Topic: Topic: Medicare Speaks 2016: Keeping you informed and updated U.S. Virgin Islands

Date: Wednesday, October 12
Time: 9:00 a.m.-12:00 p.m.
Type of Event: Face-to-face
http://medicare.fcso.com/Events/0354846.asp

Medicare Speaks 2016 Tallahassee

Date: Wednesday-Thursday, November 2-3
Time: 7:30 AM-4:15 PM
Type of Event: Face-to-face
http://medicare.fcso.com/Medicare_Speaks/0343242.pdf

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 *http://www.fcsouniversity.com*, 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.

MLN Connects®

CMS MLN Connects® Provider eNews

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*® Provider eNews 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 e-News to their membership as appropriate.

MLN Connects® Provider eNews for August 25, 2016

MLN Connects® Provider eNews for August 25, 2016

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News & Announcements

- ICD-10: Updated Questions and Answers
- IMPACT Act Standardized Assessment Data: Comments due September 12

Provider Compliance

- Lumbar Spinal Infusion

Upcoming Events

- SNF Quality Reporting Program Webcast — September 14
- National Partnership to Improve Dementia Care and QAPI Call — September 15

- Comparative Billing Report on PAP/RAD and Accessories — September 21

Medicare Learning Network® Publications & Multimedia

- Next Generation Accountable Care Organization – Implementation MLN Matters® Article — New
- Medicare and Medicaid Basics Booklet — New
- PQRS Call: Audio Recording and Transcript — New
- Global Surgery Information Session: Audio Recording and Transcript — New

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MLN Connects® Provider eNews for September 1, 2016

MLN Connects® Provider eNews for September 1, 2016

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News & Announcements

- PY 2015 Medicare ACO Results
- EHR Incentive Programs: Submit Comments on Proposed Rule by September 6
- TEP on IMPACT Act Quality Measures: Nominations due September 7
- ESRD QIP Preview Period for PY 2017 Extended to September 30
- New ST PEPPER Available
- ICD-10 Assessment and Maintenance Toolkit
- Are You Required to Comply with Electronic Standards?
- September is Prostate Cancer Awareness Month

Provider Compliance

- Psychiatry and Psychotherapy

Upcoming Events

- SNF Quality Reporting Program Webcast — September 14
- National Partnership to Improve Dementia Care and QAPI Call — September 15
- SNF Value-Based Purchasing Program Call — September 28

Medicare Learning Network® Publications & Multimedia

- September 2016 Catalog Available
- HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Revised
- Guided Pathways to Medicare Resources Provider Specific Booklet — Revised
- Suite of Products & Resources for Rural Health Providers Educational Tool — Revised
- Medicare Part B Immunization Billing Fact Sheet — Reminder
- Vaccine and Vaccine Administration Payments under Medicare Part D Fact Sheet — Reminder
- Suite of Products & Resources for Compliance Officers Educational Tool — Reminder

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MLN Connects® Provider eNews for September 8, 2016

MLN Connects® Provider eNews for September 8, 2016

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News & Announcements

- EHR Incentive Program 2017 Medicare Payment Adjustment for Hospitals
- IRF and LTCH QRP Provider Preview Reports Available until September 30
- DMEPOS Suppliers: Use Revised CMS-855S Beginning January 1
- DMEPOS Fee Schedule: Corrections to the July 2016 File
- DMEPOS Fee Schedule: Assignment Monitoring Data Posted
- SNF 30-Day Potentially Preventable Readmission Measure — Updated
- 2015 PQRS Feedback Reports and 2015 Annual QRURs: Are You Ready?
- New Look for Think Cultural Health
- Healthy Aging® Month — Discuss Preventive Services with your Patients

Provider Compliance

- Coudé Tip Catheters

Claims, Pricers & Codes

- October 2016 Average Sales Price Files Now Available

Upcoming Events

- SNF Quality Reporting Program Webcast — September 14
- National Partnership to Improve Dementia Care and QAPI Call — September 15
- SNF Value-Based Purchasing Program Call — September 28
- 2015 Annual QRURs Webcast — September 29
- Comparative Billing Report on Modifier 25: OB/GYN Webinar — October 5

Medicare Learning Network® Publications & Multimedia

- Advance Care Planning Fact Sheet — New

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.

MLN Connects® Provider eNews for September 15, 2016

MLN Connects® Provider eNews for September 15, 2016

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News & Announcements

- Plans for the Quality Payment Program in 2017: Pick Your Pace
- CMS Finalizes Rule to Bolster Emergency Preparedness of Certain Facilities
- DMEPOS Competitive Bidding Payment Amounts and Contract Offers for Round 1 2017
- New Data: 49 States plus DC Reduce Avoidable Hospital Readmissions
- SNF QRP Provider Training Questions and Feedback on MDS 3.0
- EHR Incentive Programs: Materials from August Webinars Available
- ICD-10 Coordination and Maintenance Committee Meeting: Materials Available
- Track ICD-10 Progress and Manage Your Revenue Cycle

Provider Compliance

- Advanced Life Support Ambulance Services: Insufficient Documentation

Upcoming Events

- SNF Value-Based Purchasing Program Call – September 28
- 2015 Annual QRURs Webcast – September 29
- IMPACT Act: Data Elements and Measure Development Call – October 13

Medicare Learning Network® Publications & Multimedia

- Overview of the SNF Value-Based Purchasing Program MLN Matters® Article – New
- Fee-For-Service Data Collection System: Clinical Laboratory Fee Schedule Data Reporting Template MLN Matters® Article – New
- Clinical Laboratory Fee Schedule Fact Sheet – Revised
- ICD-10-CM/PCS Myths and Facts Fact Sheet – Revised
- ICD-10-CM Classification Enhancements Fact Sheet – Revised
- ICD-10-CM/PCS The Next Generation of Coding Fact Sheet – Revised
- General Equivalence Mappings Frequently Asked Questions Booklet – Revised
- Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting Educational Tool – Revised
- Preventive Services Educational Tool Reminder

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MLN Connects® Provider eNews for September 22, 2016

MLN Connects® Provider eNews for September 22, 2016

View this edition as a PDF

News & Announcements

- Revised CMS-855R Application Available: Reassignment of Medicare Benefits
- IRF and LTCH QRP Provider Preview Reports – Review Your Data by September 30
- eCQI Resource Center has News and Resources

Provider Compliance

- Reporting Changes in Ownership

Upcoming Events

- SNF Value-Based Purchasing Program Call – September 28
- 2015 Annual QRURs Webcast – September 29
- Emergency Preparedness Requirements Call – October 5
- IMPACT Act: Data Elements and Measure Development Call – October 13
- Comparative Billing Report on CMT of the Spine Webinar – October 19

Medicare Learning Network® Publications & Multimedia

- Fee-For-Service Data Collection System: CLFS Data Reporting Template MLN Matters® Article – Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians web-Based Training – Revised
- Transitional Care Management Services Fact Sheet – Revised
- Federally Qualified Health Center Fact Sheet – Revised
- Health Professional Shortage Area Physician Bonus Program Fact Sheet – Revised
- Hospital Outpatient Prospective Payment System Fact Sheet – Revised
- Dual Eligible Beneficiaries under the Medicare and Medicaid Programs Fact Sheet – Revised
- Medicare Ambulance Transports Booklet – Revised
- Acute Care Hospital Inpatient Prospective Payment System Booklet – Revised
- Critical Access Hospital Booklet – Revised

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2016-2017 influenza resources for health care professionals

Provider types affected

All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

What you need to know

- Keep this special edition *MLN Matters*® article and refer to it throughout the 2016-2017 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Remember to immunize yourself and your staff.

Introduction

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare's coverage of the annual flu shot.

As a reminder, please help prevent the spread of flu by immunizing yourself and your staff!

Know what to do about the flu!

Payment rates for 2016-2017

Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and Current Procedure Terminology (CPT®) codes and payment rates for personal influenza (flu) and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the average wholesale price (AWP), except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Effective for services provided on August 1, 2016, through those provided on July 31, 2017, the following Medicare Part B payment allowances for HCPCS and CPT® codes apply.

CPT® codes

CPT® code	Effective dates	Payment allowance
90630	8/1/2016 – 7/31/2017	Pending
90653	8/1/2016 – 7/31/2017	Pending
90654	8/1/2016 – 7/31/2017	Pending
90655	8/1/2016 – 7/31/2017	Pending
90656	8/1/2016 – 7/31/2017	Pending
90657	8/1/2016 – 7/31/2017	Pending
90661	8/1/2016 – 7/31/2017	Pending
90662	8/1/2016 – 7/31/2017	Pending
90672	8/1/2016 – 7/31/2017	Pending
90673	8/1/2016 – 7/31/2017	Pending
90674	8/1/2016 – 7/31/2017	Pending
90685	8/1/2016 – 7/31/2017	Pending
90686	8/1/2016 – 7/31/2017	Pending
90687	8/1/2016 – 7/31/2017	Pending
90688	8/1/2016– 7/31/2017	Pending

HCPCS codes

HCPCS code	Effective dates	Payment allowance
Q2035	8/1/2016 – 7/31/2017	Pending
Q2036	8/1/2016 – 7/31/2017	Pending
Q2037	8/1/2016 – 7/31/2017	Pending
Q2038	8/1/2016 – 7/31/2017	Pending
Q2039	8/1/2016– 7/31/2017	Flu vaccine adult – Not otherwise classified: Payment allowance is to be determined by the local claims processing contractor.

The above pricing, and any required updates, will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*.

Educational products for health care professionals

The *Medicare Learning Network*® (*MLN*®) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and its administration.

1. *MLN*® influenza related products for health care professionals

- **Medicare Part B Immunization Billing chart** - *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf*

FLU

From previous page

- **Preventive Services chart** - *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html*
- **MLN Preventive Services Educational Products web page** - *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html*

2. Other CMS Resources

- Immunizations web page - *https://www.cms.gov/Medicare/Prevention/Immunizations/index.html*
- Prevention General Information - *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*
- CMS Frequently Asked Questions - *https://questions.cms.gov/faq.php*
- Medicare Benefit Policy Manual - Chapter 15, Section 50.4.4.2 – Immunizations *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*
- ***Medicare Claims Processing Manual*** – Chapter 18, Preventive and Screening Services *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*

3. Other resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2016–2017 flu season:

- **Advisory Committee on Immunization Practices** - *http://www.cdc.gov/vaccines/acip/index.html*
- Other sites with helpful information include:
  - **Centers for Disease Control and Prevention** - *http://www.cdc.gov/flu*
  - **Flu.gov** - *http://www.flu.gov*
  - **Food & Drug Administration** - *http://www.fda.gov*
  - **Immunization Action Coalition** - *http://www.immunize.org*
  - **Indian Health Services** - *http://www.ihs.gov*
  - **National Alliance for Hispanic Health** - *http://www.hispanichealth.org*
  - **National Foundation For Infectious Diseases** - *http://www.nfid.org/influenza*
  - **National Library of Medicine and NIH Medline Plus** - *https://medlineplus.gov/immunization.html*
  - **National Vaccine Program** - *http://www.hhs.gov/nvpo*
  - **Office of Disease Prevention and Health Promotion** - *http://healthfinder.gov/FindServices/Organizations/Organization/HR2013/office-of-disease-prevention-and-health-promotion-us-department-of-health-and-human-services*
  - **World Health Organization** - *http://www.who.int/en*

Beneficiary information

For information to share with your Medicare patients, please visit *http://www.medicare.gov*.

MLN Matters® Number: SE1622
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Manage your EDI information through SPOT

Starting September 26, 2016, the electronic data interchange (EDI) application will be available for Medicare providers through First Coast Service Options' (First Coast) Secure Provider Online Tool (SPOT).

EDI is used for *managing transaction data such as claims, claim status, and remittances* between First Coast and medical providers. Using SPOT to manage EDI enrollment information will save Medicare providers time and money by no longer having to mail in forms to keep their information current.

Medical providers use the EDI form often to add new practitioners to their electronic billing profile, change electronic remittance advice information, and request *First Coast's free Part B Medicare billing software, ABILITY I PC-ACE*. Providers also use the EDI form to change billing agents or clearinghouses. Starting September 26, each of these transactions can be made using SPOT.

The addition of the EDI application form is one of several recent enhancements to SPOT. First Coast expanded SPOT to offer cost reporting for hospitals, nursing homes and end-stage renal disease providers in April. Last month, First Coast added live chat to keep providers informed on top issues and easily connect with the SPOT support staff when necessary.

Like PC-ACE software, First Coast offers SPOT to providers at no charge. SPOT gives Medicare providers *several time-saving features* including the ability to view claims status and patient eligibility information online, conduct detailed data analysis at the claim and provider levels, reopen claims to make clerical corrections on multiple lines, and submit redeterminations and additional development responses (ADRs).

If you have not established your SPOT account and want to take advantage of the EDI enhancement, sign up for SPOT today. First Coast provides a *step-by-step guide* to assist you in establishing your account.

First Coast Service Options Phone Numbers

*(**Note:** Specific geographic contact information is noted when phone numbers and addresses are different for providers in Florida, U.S. Virgin Islands or Puerto Rico.)*

Customer service
Monday to Friday
8:00 a.m. to 4:00 p.m
888-664-4112 (FL/USVI)
877-908-8433 (Puerto Rico)
877-660-1759 (TDD-FL/USVI)
888-216-8261 (TDD-Puerto Rico)

Electronic data interchange
888-670-0940 (FL/USVI)
888-875-9779 (Puerto Rico)

Interactive Voice Response
877-602-8816

Provider education/outreach
Event registration hotline
904-791-8103

Overpayments
904-791-8123

SPOT Help Desk
FCSOSPOTHelp@fcso.com
855-416-4199

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Medicare EDI
Electronic claim filing
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

Fraud and abuse
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

FOIA requests
Provider audit/reimbursement
(relative to cost reports and audits)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

General Inquiries
Online Form (Click here)
Email: *AskFloridaA@fcso.com*

Local coverage determinations
Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, auto accident settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections and debt recovery
Repayment, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Credit balance reports
First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

Post-pay medical review
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

Redetermination
Florida:
Medicare Part A Redetermination/Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

Redetermination (cont'd)
U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Special delivery/courier services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

DME regional carrier (DMERC)
DME, orthotic, prosthetic device, take-home supply, oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare
Palmetto GBA
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health/hospice intermediary
Palmetto GBA
Medicare Part A
34650 US HWY 19N
Palm Harbor, FL 34684

Contact CMS

Centers for Medicare & Medicaid Services (CMS) (*https://www.cms.gov/*)
Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations

ROATLFM@CMS.HHS.GOV

Office of Inspector General (OIG)
Medicare fraud hotline
800-HHS-TIPS (800-447-8477)

Medicare beneficiary customer service
1-800-MEDICARE
1-800-633-4227

Hearing and speech impaired (TDD)
1-800-754-7820