

C Medicare A CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

October 2016



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CMS finalizes the new Medicare quality payment program

On October 14, HHS finalized its policy implementing the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) incentive payment provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), collectively referred to as the Quality Payment Program. The new Quality Payment Program will gradually transform Medicare payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care system.

The final rule with comment period offers a fresh start for Medicare by centering payments around the care that is best for the patients, providing more options to clinicians for innovative care and payment approaches, and reducing administrative burden to give clinicians more time to spend with their patients, instead of on paperwork.

Accompanying the announcement is a new [Quality Payment Program](#) website, which will explain the new program and help clinicians easily identify the measures most meaningful to their practice or specialty.

For More Information:

- [Final Rule](#) and [Executive Summary](#)



- [Press Release](#)
- [Fact Sheet](#)
- [Quality Payment Program](#)

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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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General Information

Internet-only manual updates to correct errors and omissions

Note: This article was revised on October 17, 2016, to reflect a new change request (CR). That CR revised Chapter 8 to correct minor omissions in Sections 10.2 and 70. Additionally, Section 20 was removed from the CR in order to rescind unclear wording (bold under “Key points of CR 9748”). The transmittal number, CR release date and link to the transmittal were also changed. All other information remains the same. This information was previously published in the [September 2016 Medicare A Connection, page 18](#).

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 that was initially added by CR 9748 in Transmittal R227BP to §20 of Chapter 8, regarding the scope and purpose of Medicare’s post-hospital extended care benefit, inadvertently included unclear wording and has been rescinded**

by Transmittal R228BP. As a result, the original version of this section’s text, as it read prior to that revision, is now restored.

‘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/R228BP.pdf>.
- The thirds updates the *Medicare Claims Processing Manual* at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3612CP.pdf>.

Document history

Date of change	Description
October 17, 2016	The article was revised October 17, 2016, to reflect a new CR. That CR revised Chapter 8 to correct minor omissions in Sections 10.2 and 70. Additionally, Section 20 was removed from the CR in order to rescind unclear wording. The transmittal number, CR release date and link to the transmittal were also changed.
September 18, 2016	Initial article post

MLN Matters® Number: MM9748
 Related Change Request (CR) #: CR 9748
 Related CR Release Date: October 13, 2016
 Effective Date: October 18, 2016
 Related CR Transmittal #: R101GI, R228BP, and R3612CP
 Implementation Date: October 18, 2016

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Fingerprint-based background check began August 6, 2014

Note: This article was rescinded October 17, 2016. For information on the Fingerprint-based Background Check requirement, view *MLN Matters*® article SE1417, “Implementation of Fingerprint-Based Background Checks”, available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf>. This information was previously published in the *September 2014 Medicare B Connection*, page 33.

MLN Matters® Number: SE1427 *Rescinded*
 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

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Amount in controversy updates for 2017

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides for annual reevaluation of the dollar amount in controversy (AIC) required for an administrative law judge (ALJ) hearing (third level review) and federal district court review (fifth level review).

For requests made on or after January 1, 2017:

- The amount that must remain in controversy for ALJ hearing requests is increased to \$160.
- The amount that must remain in controversy for federal district court review is increased to \$1,560.

Processing Issues

Reason code W7099 editing incorrectly

Issue

Errors with reason code W7099 (Claims with pass-through or non-pass-through drug or biological lacks OPPS payable procedure) were causing affected claims to be suspended.

Resolution

A workaround provided by the Center for Medicare & Medicaid Services (CMS) was implemented by First Coast



Service Options Inc. October 24; all claims have been reprocessed.

Status/date resolved

Closed/October 24, 2016.

Provider action

No action is required by the provider.

Current processing issues

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

Correct your claims on the 'SPOT'

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



Ambulance inflation factor for 2017 and productivity adjustment

Provider types affected

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

Provider action needed

Change request (CR) 9811 furnishes the 2017 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. Make sure that your billing staffs are aware of the change.

Background

CR 9811 furnishes the 2017 ambulance inflation factor (AIF) for determining the payment limit for ambulance services required by Section 1834(l)(3)(B) of the Social Security Act (the Act).

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

Section 3401 of the Affordable Care Act requires that specific prospective payment system (PPS) and fee schedule (FS) update factors be adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary of Health and Human Services (the Secretary) for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period).

The MFP for 2017 is 0.3 percent and the CPI-U for 2017 is 1.0 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results



in a negative AIF update. Therefore, the AIF for 2017 is 0.7 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Additional information

The official instruction, CR 9811, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3625CP.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: MM9811

Related Change Request (CR) #: CR 9811

Related CR Release Date: October 14, 2016

Effective Date: January 1, 2017

Related CR Transmittal #: R3625CP

Implementation Date: January 3, 2017

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January update to the laboratory NCD edit software

Provider types affected

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

Provider action needed

Change request (CR) 9806 announces changes that will be included in the January 2017 quarterly release of the edit module for clinical diagnosis laboratory services. Make sure your billing staffs are aware of these changes to ensure proper billing to Medicare.

Background

The national coverage determination (NCD) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published November 23, 2001. Medicare developed nationally uniform software that was incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12-190.34) were processed uniformly throughout the United States effective April 1, 2003.

CR 9806 communicates requirements to Medicare system maintainers and the MACs regarding changes to the NCD code lists used for laboratory claim edit software for January 2017. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and

biannual updates of the ICD-10-CM codes. Please see Section II (business requirements table) of CR 9806 for the lengthy list of codes added or deleted. Note that where codes are deleted, the effective date of deletion is September 30, 2016, and the effective date for codes added is October 1, 2016.

Additional information

The official instruction, CR 9806, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3614CP.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: MM9806
 Related Change Request (CR) #: CR 9806
 Related CR Release Date: September 23, 2016
 Effective Date: October 1, 2016
 Related CR Transmittal #: R3614CP
 Implementation Date: January 3, 2017

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Update to hepatitis B deductible and coinsurance and screening Pap smear claim processing

Provider types affected

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

What you need to know

Change request (CR) 9778 informs MACs about the updates to language regarding coinsurance and deductible for hepatitis B in the Chapter 18, Section 10 of the *Medicare Claims Processing Manual* to show that coinsurance and deductible for hepatitis B virus vaccine are waived. This is not a change in current policy and the CR only updates the manual to show current policy. CR 9778 also removes subsection D from Sections 30.8 and 30.9 of Chapter 18 of the manual, which contained incorrect claim processing instructions regarding processing claims with HCPCS code G0476, HPV screening, when submitted on a type of bill other than 12x, 13x, 14x, 22x, 23x, and 85x.

Additional information

The official instruction, CR 9778, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3615CP.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: MM9778
 Related Change Request (CR) #: CR 9778
 Related CR Release Date: September 23, 2016
 Effective Date: December 27, 2016
 Related CR Transmittal #: R3615CP
 Implementation Date: December 27, 2016

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Implementation of new influenza virus vaccine code

Provider types affected

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

Provider action needed

Change request (CR) 9793 which informs MACs about the changes to instructions for payment and edits for the common working file (CWF) to include influenza virus vaccine code 90674 (Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use) as payable for claims with dates of service on or after August 1, 2016, processed on or after January 3, 2017. Make sure that your billing staffs are aware of these changes.

Background

CR 9793 provides instructions for payment and edits to include influenza virus vaccine code 90674. Medicare waives coinsurance and deductibles for code 90674. Medicare will pay for code 90674 based on reasonable costs when submitted by:

- Hospitals on type of bill (TOB) 12x and 13x
- Skilled nursing facilities on TOB 22x and 23x
- Home health agencies on TOB 34x
- Hospital-based renal dialysis facilities on 72x, and
- Critical access hospitals (CAHs) on TOB 85x

MACs will pay for influenza virus vaccine code 90674 based on the lower of the actual charge or 95 percent of the average wholesale price (AWP) to:

- Indian health services (IHS) hospitals submitting claims on TOB 12x and 13x
- IHS CAHs submitting claims on TOB 85x
- Comprehensive outpatient rehabilitation facilities using TOB 75x, and
- Independent renal dialysis facilities using TOB 72x

It is important to note that MACs will hold institutional claims with code 90674 with dates of service on or after January 1, 2017, through February 20, 2017, until the fiscal intermediary shared system (FISS) changes are implemented February 20, 2017.

Medicare will issue further instructions on how to handle

claims for **code 90674 with dates of service from August 1, 2016, through December 31, 2016.**

Medicare will use the Centers for Medicare & Medicaid Services (CMS) seasonal influenza vaccines pricing web page at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html> to determine the payment rate for influenza virus vaccine code 90674. This applies to professional claims with dates of service on or after August 1, 2016.

Coinsurance and deductible do not apply.

Additional information

The official instruction, CR 9793, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3617CP.pdf>.

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

Document history

Date of change	Description
October 21, 2016	The article was revised to correct a date on page 2 (<i>Background</i> section) in bold. The dates should have read, "... from August 1, 2016, through December 31, 2016.
September 30, 2016	Initial article post

MLN Matters® Number: MM9793
 Related Change Request (CR) #: CR 9793
 Related CR Release Date: September 30, 2016
 Effective Date: August 1, 2016
 Related CR Transmittal #: R3617CP
 Implementation Date: January 3, 2017

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Implementation of LTCH prospective payment system (PPS) based on specific clinical criteria

Note: This article was revised October 19, 2016, to include a link to *MLN Matters*® article SE1627, which contains clarifying information. This link is in the *Additional information* section of this article. This information was previously published in the *October 2015 Medicare A Connection*, pages 43-44.

Provider types affected

This *MLN Matters*® article is intended for long-term care hospitals (LTCH) that submit claims to Medicare administrative contractors (MACs) for LTCH services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

This article is based on change request (CR) 9015, which informs you that Section 1206(a) of Public Law 113–67 (2013 Bipartisan Budget Act) amended Section 1886(m) of the Social Security Act (the Act) to establish patient-level criteria for standard payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015.

Caution – what you need to know

This revision to payments under the existing LTCH PPS will establish two separate payment categories for LTCH patients: Standard and Site Neutral. See the *Background* and *Policy* sections below for details.

Go – what you need to do

Make sure that your billing staffs are aware of these changes.

Background

Medicare currently pays for inpatient hospital services for LTCH discharges under the LTCH PPS.

- Under this payment system, the Centers for Medicare & Medicaid Services (CMS) largely sets payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness. A hospital generally receives a single payment for the case based on the payment classification, that is, the MS-LTC-DRGs assigned at discharge.
- LTCHs are required to meet the same Medicare conditions of participation (COPs) as acute care hospitals that are paid under the inpatient prospective payment system (IPPS). Under existing law, the primary criteria for a hospital to be designated as an LTCH for Medicare payment purposes is a "greater than 25 day average length of stay" requirement.

Until the enactment of the 2013 Bipartisan Budget Act (Public Law 113-67), however, there were no clinical criteria concerning the patients treated in LTCHs. Specifically, Section 1206 of this Act establishes two distinct payment categories under the LTCH PPS:

- "Standard" payments for patient discharges meeting specific clinical criteria; and

- "Site neutral" payments for those discharges that do not meet the specified clinical criteria.

This revision to payments under the existing LTCH PPS will establish two separate payment categories for LTCH patients:

- Upon discharge, LTCH cases meeting specific clinical criteria will be paid a **standard** LTCH PPS payment (that is, what is generally paid under existing LTCH PPS policy); and
- Upon discharge, those cases not meeting specific clinical criteria will be paid based on a "**site neutral**" basis, which is the lesser of an "IPPS-comparable" payment amount or 100 percent of the estimated cost of the case.

In order to be paid at the **standard** LTCH PPS amount, an LTCH patient must either:

- Have been admitted directly from an IPPS hospital during which at least three days were spent in an intensive care unit (ICU) or coronary care unit (CCU), but the discharge must not be assigned to a psychiatric or rehabilitation MS-LTC-DRG in the LTCH; or
- Have been admitted directly from an IPPS hospital and the LTCH discharge includes the procedure code for ventilator services of at least 96 hours (ICD-10-CM procedure code 5A1955Z) but must not be assigned to a psychiatric or rehabilitation MS-LTC-DRG in the LTCH.

Existing LTCH PPS policies, such as the short-stay outlier (SSO) policy and the interrupted stay policy, will continue to apply in determining the standard LTCH PPS payment for those discharges meeting specific clinical criteria.

The "**site neutral**" amount will be paid for patients discharged from the LTCH that do not meet one or both of the above criteria. Where a site neutral payment is made, MACs will place remittance advice remarks code N741 (This is a site neutral payment.) on the remittance advice.

Site neutral payments shall not change the beneficiary's out of pocket costs. Coinsurance, if applicable, is payable by the beneficiary for the number of days used. The hospital subtracts the coinsurance amount from the Medicare payment. Days after benefits are exhausted are not charged against the beneficiary's utilization whether or not the hospital receives the full MS-LTC-DRG payment.

If there is at least 1 day of utilization left at the time of admission and that day is also a day of entitlement (for example, a day before the beneficiary discontinued voluntary Part A entitlement by not paying the premium), if a site neutral payment is made, the remaining "inlier" days of the stay will be considered covered until the site neutral high cost outlier is reached even though the beneficiary is not using any Medicare covered days. The beneficiary shall not be responsible for non-utilization days. Once the beneficiary reaches the site neutral high cost outlier threshold, the beneficiary may choose to use life-time reserve days.

See **LTCH**, next page

Further information on LTCH PPS based on specific clinical criteria

Provider types affected

This *MLN Matters*[®] special edition (SE) article is intended for long-term care hospitals (LTCHs) that submit claims to Medicare administrative contractors (MACs) for LTCH services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9015, Transmittal 1544, Implementation of LTCH PPS based on specific clinical criteria, issued September 22, 2015, describes the immediately preceding hospital as an Inpatient PPS hospital, which is inconsistent with the policy set forth in the *Code of Federal Regulations*. The regulations at CFR 412.522 specifies the immediately preceding discharge is from a “subsection (d) hospital”, which in general, means a hospital located in one of the 50 states or the District of Columbia other than certain specified IPPS-excluded hospitals (that is, psychiatric hospitals, rehabilitation hospitals, children’s hospitals, LTCHs, and cancer hospitals) (see §412.503).

Medicare’s claim processing system was programmed correctly to identify subsection (d) hospitals, however, the patient may have had an immediately preceding inpatient stay at a subsection (d) hospital that is not present in the Medicare claims processing system. For example, the patient may have used their Veteran Affairs benefits or received inpatient care at a military treatment facility that qualifies as an “immediately preceding” stay (prior to admission to the LTCH) if verified by the MAC. In such an occurrence, upon receipt of a site neutral payment, the LTCH shall contact their MAC who will work with

the LTCH to obtain the documentation it finds sufficient to demonstrate that the applicable criteria for exclusion from the site neutral payment rate have been met and adjust the applicable LTCH claim to make any appropriate adjustments to payment.

Additional information

The article related to CR 9015, MM9015, is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9015.pdf>.

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

MLN Matters[®] Number: SE1627
 Related Change Request (CR) #: CR 9015
 Effective Date: Discharges in cost reporting periods on or after October 1, 2015
 SE Article Release Date: October 18, 2016
 Related CR Transmittal #: R1544OTN
 Implementation Date: October 5, 2015

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LTCH

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Additional information

The official instruction, CR 9015, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1544OTN.pdf>.

See important clarifying information in *MLN Matters*[®] article SE1627 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1627.pdf>.

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

MLN Matters[®] Number: MM9015 *Revised*
 Related Change Request (CR) #: CR 9015

Effective Date: Discharges in Cost Reporting Periods on or after October 1, 2015
 Related CR Release Date: September 22, 2015
 Related CR Transmittal #: R1544OTN
 Implementation Date: October 5, 2015

Document history

- **October 19, 2016:** Article revised to include a link to SE1627.
- **September 22, 2015:** Initial issuance

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Allogeneic hematopoietic stem cell transplantation

Note: This article was revised September 26, 2016, to correct the language regarding the submission of professional claims in the “Background” section of the article. All other information remains the same. This information was previously published in the July 2016 Medicare A Connection, pages 23-25.

Provider types affected

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

Provider action needed

CR 9620, from which this article was developed, notifies providers that effective for claims with dates of service on and after January 27, 2016, for the use of allogeneic hematopoietic stem cell transplantation (HSCT) for treatment of multiple myeloma, myelofibrosis, and sickle cell disease is covered by Medicare, but only if provided in the context of a Medicare-approved clinical study meeting specific criteria under the coverage with evidence development (CED) paradigm.

CR 9620 also clarifies the ICD-9 and ICD-10 diagnosis codes for allogeneic HSCT for treatment of myelodysplastic syndromes (MDS) in the context of a Medicare-approved, prospective clinical study under CED. Specifically, for dates of service on or after August 4, 2010, through September 30, 2015, the ICD-9-CM diagnosis codes are 238.72, 238.73, 238.74, or 238.75 **and** clinical trial ICD-9-CM diagnosis code V70.7. For dates of service on or after October 1, 2015, the ICD-10-CM diagnosis codes are D46.A, D46.B, D46.C, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, or D46.Z **and** clinical trial ICD-10-CM diagnosis code Z00.6. Make sure your billing staff is aware of these determinations.

Background

HSCT is a process that includes mobilization, harvesting, and transplant of stem cells and the administration of high-dose chemotherapy and/or radiotherapy prior to the actual transplant. During the process stem cells are harvested from either the patient (autologous) or a donor (allogeneic) and subsequently administered by intravenous infusion to the patient.

Multiple myeloma is a neoplastic plasma-cell disorder. Myelofibrosis is a stem cell-derived hematologic disorder. Sickle cell disease is a group of inherited red blood cell disorders created by the presence of abnormal hemoglobin genes. On April 30, 2015, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request from the American Society for Blood and Marrow Transplantation (ASBMT) to reconsider its policy and expand coverage of allogeneic HSCT for sickle cell disease, myelofibrosis, multiple myeloma, and rare diseases.

Myelodysplastic syndrome (MDS) refers to a group of diverse blood disorders in which the bone marrow does



not produce enough healthy, functioning blood cells. On August 4, 2010, CMS issued a final decision stating that allogeneic HSCT for MDS is covered by Medicare only if provided pursuant to a Medicare-approved clinical study under CED. CR 7137 (see the article, MM7137 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7137.pdf>) provides specific ICD-9 related coding and claim processing requirements regarding this particular coverage decision, and CRs 8197 and 8691 (see MM8197 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8197.pdf> and MM8691 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.pdf>) provide ICD-10 related coding requirements. On November 30, 2015, CMS accepted a formal request from the national marrow donor program (NMDP) to clarify the list of ICD-9-CM and ICD-10-CM diagnosis codes covered for allogeneic HSCT for the treatment of MDS in the context of a Medicare-approved clinical study under CED.

On January 27, 2016, CMS issued a final decision to expand national coverage of items and services necessary for research in an approved clinical study via coverage with evidence development (CED) under Section 1862(a) (1)(E) of the Social Security Act (the Act) for allogeneic HSCT for the following indications:

- Multiple myeloma
- Myelofibrosis
- Sickle cell disease

Refer to the following Medicare manual sections for more information regarding this NCD and further billing instructions specific to this NCD and the business requirements specific to CR 9620:

- Chapter 1, Section 110.23, of the *Medicare NCD Manual*, which is attached to the CR 9620 NCD transmittal at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R191NCD.pdf>.
- Chapter 1, Section 310.1, of the *Medicare NCD*

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Manual, available at https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf, and

- Chapter 32, Sections 69 and 90, of the *Medicare Claims Processing Manual*, available at <https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c32.pdf>.

Please note, Chapter 1, Section 110.8.1 has been removed from the NCD Manual and incorporated into Chapter 1, Section 110.23.

In addition to the diagnosis codes detailed at the beginning of this article, providers need to be aware of the other billing requirements, as follows:

Inpatient claims

For claims submitted on type of bill 11x for discharges on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- ICD-10-PCS procedure code of 30230G1, 30230Y1, 30233G1, 30233Y1, 30240G1, 30240Y1, 30243G1, 30243Y1, 30250G1, 30250Y1, 30253G1, 30253Y1, 30260G1, 30260Y1, 30263G1, or 30263Y1 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**
- Condition code 30, denoting qualifying clinical trial **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
 - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
 - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Outpatient claims

For claims submitted on type of bill 13x or 85x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**
- Condition code 30, denoting qualifying clinical trial **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**

- Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
- Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Method II critical access hospital (CAH) claims

For claims submitted on type of bill 85x with revenue codes 96x, 97x, or 98x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**
- Condition code 30, denoting qualifying clinical trial **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
 - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
 - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Professional claims

For professional claims submitted for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**
- The Q0 modifier **and**
- A place of service code of 19, 21, or 22 along with the appropriate ICD-10-CM diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
 - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
 - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

For all of the above claims types submitted without the requisite coding, MACs will deny the claims using the following messages:

- **Claim adjustment reason code (CARC) 50** – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. **Note:** Refer to the

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835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- Remittance advice remarks code (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. A copy of this policy is available at <https://www.cms.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code** - Patient responsibility (PR) if an advance beneficiary notice (ABN)/hospital notice on non-coverage (HINN), otherwise contractual obligation (CO)

For claims with dates of service prior to the implementation date of CR 9620, MACs shall perform necessary adjustments only when the provider brings such claims to the attention of their MAC.

Additional information

The official instruction, CR 9620, consists of two transmittals. The first updates the *Medicare Claims Processing Manual* at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3556CP.pdf>. The second transmittal updates the *Medicare NCD Manual* at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R193NCD.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> under - How Does It Work.

Document history

Date of change	Description
September 26, 2016	The article was revised to correct the language on page 4 regarding professional claims.



Date of change	Description
July 5, 2016	The article was revised due to an updated change request (CR). That CR revised shared system maintainer (SSM) responsibility. The transmittal number, CR release date and link to the transmittal also changed.
May 9, 2016	Initial article release

MLN Matters® Number: MM9620 *Revised*
 Related Change Request (CR) #: CR 9620
 Related CR Release Date: July 1, 2016
 Effective Date: January 27, 2016
 Related CR Transmittal #: R193NCD and R3556CP
 Implementation Date: October 3, 2016

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Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Tools to improve your billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

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.

Before you file an appeal...

Each month, thousands of medical providers send written inquiries to First Coast Service Options Inc. (First Coast) to check the status of an appealed claim. Unfortunately, many of these appeals and subsequent inquiries are submitted on claims that were ineligible for appeal.

Before you appeal a denied claim, check out [these resources](#).



Retired LCDs

Renal angiography – Part AB LCD retired

LCD ID number: L33715 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for renal angiography is being retired as the limited indications for renal angiography have been incorporated into the new LCD aortography and peripheral angiography (L36767). The new LCD addresses the indications and limitations of coverage and/or medical necessity, CPT® codes, ICD-10-CM diagnosis codes, documentation guidelines, and utilization guidelines for invasive diagnostic arteriography procedures performed for the purpose of evaluating vascular disease. Therefore, the LCD for renal angiography is being retired.

Effective date

The retirement of this 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 <http://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](#).



Revisions to LCDs

Amniotic membrane sutureless placement on the ocular surface – revision to the Part AB LCD

LCD ID number: L36237 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for amniotic membrane-sutureless placement on the ocular surface was revised under the “Limitations” section of the LCD to clarify amniotic membrane for sutureless application of the eye must be cleared by, or registered with, the U.S. Food and Drug Administration (FDA).

Effective date

This LCD revision is effective for services rendered **on or after October 13, 2016**. First Coast Service Options Inc.

LCDs are available through the CMS Medicare coverage database at <http://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](#).



Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the Part A and Part B LCD

LCD ID number: L33270 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was revised to replace ICD-10-CM diagnosis codes M89.9 and M94.9 with ICD-10-CM diagnosis code range M85.80-M85.9 in the “ICD-10 Codes that Support Medical Necessity” section of the LCD for HCPCS code J0897 (Prolia®).

Effective date

This LCD revision is effective for services rendered **on or after October 14, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://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](#).

Noncovered services – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for noncovered services was revised to remove Current Procedural Terminology (CPT®)/HCPCS codes 52441, 52442, C9739, C9740, and L8699 (Prosthetic implant, not otherwise specified [when used for the transprostatic urethral lift implant]) under the “CPT®/HCPCS Codes” sections of the LCD, due to the development of a new LCD (prostatic urethral lift [PUL] - L36775). The new LCD-Prostatic Urethral Lift (PUL) is currently in the 45-day notice period and will become effective 10/31/2016.

Transthoracic echocardiography (TTE) – revision to the Part AB LCD

LCD ID number: L33768 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request to include a diagnosis code when transthoracic echocardiography (TTE) is performed to monitor cardiac toxicity of chemotherapeutic agents during therapy, the local coverage determination (LCD) for transthoracic echocardiography was revised to add ICD-10-CM diagnosis code Z01.89 (Encounter for other specified special examinations) to the “ICD-10 Codes that Support Medical Necessity” section of the LCD.

Screening and diagnostic mammography – revision to the Part A and Part B LCD

LCD ID number: L36342 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 9631 (Coding Revisions to National Coverage Determinations), the local coverage determination (LCD) for screening and diagnostic mammography was revised to remove unspecified ICD-10-CM diagnosis codes C50.019, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.919, C50.929, C56.9, C78.00, C79.60, D05.00, D05.10, D05.80, D05.90, D24.9, D48.60, N60.09, N60.19, N60.29, N60.39, N60.49, N60.89, N60.99, S20.00XA, S21.009A, S21.019A, S21.029A, S21.039A, S21.049A, S21.059A, S28.219A, and S28.229A from the “ICD-10 Codes that Support Medical Necessity” section of the LCD for *Current Procedural Terminology* (CPT®)/HCPCS codes 77055, 77056, G0204, G0206, and G0279.

Effective date

The LCD revision to remove CPT®/HCPCS codes 52441, 52442, C9739, C9740, and L8699 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 <http://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](#).

Effective date

This LCD revision is effective for claims processed **on or after October 20, 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 <http://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](#).

In addition, based on CR 9677 (Annual Update of the International Classification of Diseases), ICD-10-CM diagnosis code N61 has been deleted from the “ICD-10 Codes that Support Medical Necessity” section of the LCD for CPT®/HCPCS codes 77055, 77056, G0204, G0206, and G0279.

Effective date

This LCD revision is effective for services rendered **on or after October 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://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](#).

Additional Information

2017 ICD-10-CM coding changes

The 2017 update to the ICD-10-CM diagnosis coding structure is effective for services rendered on or after October 1, 2016. The First Coast Service Options Inc. (First Coast) medical policy team has evaluated all active local coverage determinations (LCDs) for diagnosis criteria that are impacted by the 2017 ICD-10-CM update. As a reminder, diagnosis codes included in an LCD are surrogate to the indications addressed within the LCD and providers are required to bill the highest level of specificity for the applicable diagnosis code when reporting services.

The following table lists the LCDs affected and the specific conditions revised as a result of the 2017 ICD-10-CM update:

LCD database ID number	LCD title	2017 changes
L33256	3D Interpretation and Reporting of Imaging Services	Removed diagnosis code R93.4 for procedure codes 76376 and 76377. Added diagnosis codes R93.41, R93.421, R93.422, and R93.49 for procedure codes 76376 and 76377.
L33268	Bendamustine hydrochloride (Treanda [®] , Bendeka [™])	Changed descriptors for diagnosis code ranges C81.10-C81.19, C81.20-C81.29, C81.30-C81.39, and C81.40-C81.49 for procedure codes J9033 (Treanda [®]) and C9399/J9999 (Bendeka [™]).
L36356	Bone Mineral Density Studies	Added diagnosis code ranges M84.751A-M84.752S, M84.754A-M84.755S, and M84.757A-M84.758S for procedure codes G0130, 77078, 77080, 77081, 77085, and 76977.

LCD database ID number	LCD title	2017 changes
L33583	Diagnostic and Therapeutic Esophago-gastro-duodenoscopy	Removed diagnosis codes F50.8, K52.2, K85.0, K85.9, and K90.4 for procedure codes 43233, 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43253, 43254, 43255, 43266, and 43270. Changed diagnosis code range K85.0-K85.9 to K85.00-K85.92 and diagnosis code range K90.0-K90.4 to K90.0-K90.49 for procedure codes 43233, 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43253, 43254, 43255, 43266, and 43270. Added diagnosis codes C49.A0, C49.A1, C49.A2, C49.A9, F50.81, F50.89, K52.21, K52.22, K52.29, K52.3, K52.831, K52.832, K52.838, K52.839, K55.30, K55.31, K55.32, K55.33, and Z79.84 for procedure codes 43233, 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43253, 43254, 43255, 43266, and 43270.

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LCD database ID number	LCD title	2017 changes
L33671	Diagnostic Colonoscopy	<p>Removed diagnosis code K55.0 for procedure codes 44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398, and 45399.</p> <p>Added diagnosis codes C49.A0, C49.A3, C49.A4, C49.A5, C49.A9, K55.011, K55.012, K55.019, K55.021, K55.022, K55.029, K55.031, K55.032, K55.039, K55.041, K55.042, K55.049, K55.051, K55.052, K55.059, K55.061, K55.062, K55.069, K55.30, K55.31, K55.32, and K55.33 for procedure codes 44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398, and 45399.</p>
L33989	Docetaxel (Taxotere)	Added diagnosis code range C49.A0-C49.A9 for procedure code J9171.
L33990	Doxorubicin HCl	Added diagnosis code range C49.A0-C49.A9 for procedure code J9000.
L33722	Doxorubicin, Liposomal (Doxil/ Lipodox)	Added diagnosis code range C49.A0-C49.A9 for procedure codes Q2049 and Q2050.

LCD database ID number	LCD title	2017 changes
L33667	Duplex Scan of Lower Extremity Arteries	<p>Removed diagnosis code I97.62 for procedure codes 93925 and 93926.</p> <p>Added diagnosis codes G97.61, G97.62, I97.620, I97.621, L76.31, L76.32, M96.840, M96.841, and S92.811A-S92.819S for procedure codes 93925 and 93926.</p> <p>Changed descriptors for diagnosis codes G97.51-G97.52, I97.618, L76.21-L76.22, and M96.830-M96.831 for procedure codes 93925 and 93926.</p>
L33674	Duplex Scanning	<p>Removed diagnosis codes K55.0 and R31.2 for procedure codes 93975 and 93976.</p> <p>Added diagnosis codes K55.011-K55.069, R31.21, and R31.29 for procedure codes 93975 and 93976.</p>
L33669	Electro-cardiography	Added diagnosis code ranges I16.0-I16.9 and T88.53XA-T88.53XS for procedure codes 93000, 93005, and 93010.
L36276	Erythropoiesis Stimulating Agents	Added diagnosis code range C49.A0-C49.A9 for procedure codes J0881 (List 2) and J0885 (List 2).
L33723	Etoposide VP-16	Added diagnosis code range C49.A0-C49.A9 for procedure code J9181.
L33997	Fluorescein Angiography	Removed diagnosis codes E08.359, E09.359, E10.359, E11.359, E13.359, H35.31, and H35.32 for procedure code 92235.

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LCD database ID number	LCD title	2017 changes
L33997 (cont)	Fluorescein Angiography	<p>Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599, diagnosis code range E10.311-E10.359 to E10.311-E10.3599, diagnosis code range E11.311-E11.359 to E11.311-E11.3599, and diagnosis code range E13.311-E13.359 to E13.311-E13.3599 for procedure code 92235.</p> <p>Added diagnosis code ranges E08.37X1-E08.37X9, E09.37X1-E09.37X9, E10.37X1-E10.37X9, E11.37X1-E11.37X9, E13.37X1-E13.37X9, H35.3110-H35.3194, and H35.3210-H35.3293 for procedure code 92235.</p>
L33670	Fundus Photography	<p>Removed diagnosis codes E08.359, E09.359, E10.359, E11.359, E13.359, H34.811, and H34.839 under the “Limitations” section of the LCD for procedure code 92250.</p> <p>Removed diagnosis codes E08.359 and E09.359 under the “ICD-10 Codes that Support Medical Necessity” section of the LCD for CPT® code 92250.</p> <p>Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599, diagnosis code range E10.311-E10.359 to E10.311-E10.3599,</p>

LCD database ID number	LCD title	2017 changes
L33670 (cont)	Fundus Photography	<p>diagnosis code range E11.311-E11.359 to E11.311-E11.3599, diagnosis code range E13.311-E13.359 to E13.311-E13.3599, and diagnosis code range H34.811-H34.839 to H34.8110-H34.8392 under the “Limitations” section of the LCD for procedure code 92250.</p> <p>Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599 and diagnosis code range E09.311-E09.359 to E09.311-E09.3599 under the “ICD-10 Codes that Support Medical Necessity” section of the LCD for CPT® code 92250.</p> <p>Added diagnosis code ranges E08.37X1-E08.37X9, E09.37X1-E09.37X9, E10.37X1-E10.37X9, E11.37X1-E11.37X9, E13.37X1-E13.37X9 under the “Limitations” section of the LCD for procedure code 92250.</p> <p>Added diagnosis code ranges E08.37X1-E08.37X9 and E09.37X1-E09.37X9 under the “ICD-10 Codes that Support Medical Necessity” section of the LCD for CPT® code 92250</p>
L33726	Gemcitabine (Gemzar)	Added diagnosis code range C49.A0-C49.A9 for procedure code J9201.
L34003	Hepatitis B Surface Antibody and Surface Antigen	<p>Removed diagnosis codes R82.7 and Z22.51 for procedure code 87340.</p> <p>Added diagnosis code range R82.71-R82.79 for procedure code 87340.</p>

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L33377	Implantable Miniature Telescope (IMT)	Removed diagnosis code H35.31 for procedure codes C1840 and 0308T. Added diagnosis code range H35.3110-H35.3194 for procedure codes C1840 and 0308T.
L34007	Intravenous Immune Globulin	Added diagnosis code G61.82 for procedure codes J1459, J1556, J1557, J1561, J1566, J1568, J1569, J1572 and J1575.
L33504	Intravitreal Bevacizumab (Avastin®)	Removed diagnosis codes E08.321, E08.331, E08.341, E08.351, E08.359, E09.321, E09.331, E09.341, E09.351, E09.359, E10.321, E10.331, E10.341, E10.351, E10.359, E11.321, E11.331, E11.341, E11.351, E11.359, E13.321, E13.331, E13.341, E13.351, E13.359, and H35.32 for procedure code C9257. Added diagnosis code ranges E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E08.3521-E08.3523, E08.3531-E08.3533, E08.3541-E08.3543, E08.3591-E08.3593, E09.3211-E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E09.3521-E09.3523, E09.3531-E09.3533, E09.3541-E09.3543, E09.3591-E09.3593, E10.3211-E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3521-E10.3523, E10.3531-E10.3533,

LCD database ID number	LCD title	2017 changes
L33504 (cont)	Intravitreal Bevacizumab (Avastin®)	E10.3541-E10.3543, E10.3591-E10.3593, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.3513, E11.3521-E11.3523, E11.3531-E11.3533, E11.3541-E11.3543, E11.3591-E11.3593, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.3513, E13.3521-E13.3523, E13.3531-E13.3533, E13.3541-E13.3543, E13.3591-E13.3593, H35.3210-H35.3213, H35.3220-H35.3223, and H35.3230-H35.3233 for procedure code C9257. Changed diagnosis code range H34.811-H34.819 to H34.8110-H34.8192 and diagnosis code range H34.831-H34.839 to H34.8310-H34.8392 for procedure code C9257.
L34011	Ionized Calcium	Changed diagnosis range K85.0-K85.9 to K85.00-K85.92 for procedure code 82330.
L34012	Leucovorin (Wellcovorin®)	Added diagnosis code range C49.A0-C49.A9 for procedure code J0640.
L33381	Low Density Lipoprotein (LDL) Apheresis	Removed diagnosis code E78.0 for procedure code 36516. Added diagnosis codes E78.00 and E78.01 for procedure code 36516.
L34014	Magnesium	Removed diagnosis code K52.2 for procedure code 83735. Added diagnosis codes K52.21-K52.29, K52.831-K52.839, and M62.84 for procedure code 83735. Changed diagnosis code range K85.0-K87 to K85.00-K87 for procedure code 83735.

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L34014 (cont)	Magnesium	Changed descriptor for diagnosis code range P03.810-P03.89 for procedure code 83735.
L33618	Major Joint Replacement (Hip and Knee)	Removed diagnosis code ranges T84.040A-T84.040S and T84.041A-T84.041S for ICD-10-CM procedure codes 0SP90JZ, 0SPB0JZ, 0SR9019, 0SR901A, 0SR901Z, 0SR9029, 0SR902A, 0SR902Z, 0SR9039, 0SR903A, 0SR903Z, 0SR9049, 0SR904A, 0SR904Z, 0SR907Z, 0SR90J9, 0SR90JA, 0SR90JZ, 0SR90KZ, 0SW90JZ, 0SRB019, 0SRB01A, 0SRB01Z, 0SRB029, 0SRB02A, 0SRB02Z, 0SRB039, 0SRB03A, 0SRB03Z, 0SRB049, 0SRB04A, 0SRB04Z, 0SRB07Z, 0SRB0J9, 0SRB0JA, 0SRB0JZ, 0SRB0KZ, and 0SWB0JZ. Added diagnosis code ranges M84.750A-M84.750S, M84.751A-M84.751S, M84.752A-M84.752S, M84.753A-M84.753S, M84.754A-M84.754S, M84.755A-M84.755S, M84.756A-M84.756S, M84.757A-M84.757S, M84.758A-M84.758S, M84.759A-M84.759S, M97.01XA-M97.01XS, and M97.02XA-M97.02XS for ICD-10-CM procedure codes 0SP90JZ, 0SPB0JZ, 0SR9019, 0SR901A, 0SR901Z, 0SR9029, 0SR902A, 0SR902Z, 0SR9039, 0SR903A, 0SR903Z, 0SR9049, 0SR904A, 0SR904Z, 0SR907Z,

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L33618 (cont)	Major Joint Replacement (Hip and Knee)	0SR90J9, 0SR90JA, 0SR90JZ, 0SR90KZ, 0SW90JZ, 0SRB019, 0SRB01A, 0SRB01Z, 0SRB029, 0SRB02A, 0SRB02Z, 0SRB039, 0SRB03A, 0SRB03Z, 0SRB049, 0SRB04A, 0SRB04Z, 0SRB07Z, 0SRB0J9, 0SRB0JA, 0SRB0JZ, 0SRB0KZ, and 0SWB0JZ. Removed diagnosis code ranges T84.042A-T84.042S and T84.043A-T84.043S for ICD-10-CM procedure codes 0SPC0JZ, 0SPD0JZ, 0SRC07Z, 0SRC0J9, 0SRC0JA, 0SRC0JZ, 0SRC0KZ, 0SRD07Z, 0SRD0J9, 0SRD0JA, 0SRD0JZ, 0SRD0KZ, 0SRT07Z, 0SRT0J9, 0SRT0JA, 0SRT0JZ, 0SRT0KZ, 0SRU07Z, 0SRU0J9, 0SRU0JA, 0SRU0JZ, 0SRU0KZ, 0SRV07Z, 0SRV0J9, 0SRV0JA, 0SRV0JZ, 0SRV0KZ, 0SRW07Z, 0SRW0J9, 0SRW0JA, 0SRW0JZ, 0SRW0KZ, 0SWC0JZ, and 0SWD0JZ. Added diagnosis code ranges M97.11XA-M97.11XS and M97.12XA-M97.12XS for ICD-10-CM procedure codes 0SPC0JZ, 0SPD0JZ, 0SRC07Z, 0SRC0J9, 0SRC0JA, 0SRC0JZ, 0SRC0KZ, 0SRD07Z, 0SRD0J9, 0SRD0JA, 0SRD0JZ, 0SRD0KZ, 0SRT07Z, 0SRT0J9, 0SRT0JA, 0SRT0JZ, 0SRT0KZ, 0SRU07Z, 0SRU0J9, 0SRU0JA, 0SRU0JZ, 0SRU0KZ,

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L33618 (cont)	Major Joint Replacement (Hip and Knee)	0SRV07Z, 0SRV0J9, 0SRV0JA, 0SRV0JZ, 0SRV0KZ, 0SRW07Z, 0SRW0J9, 0SRW0JA, 0SRW0JZ, 0SRW0KZ, 0SWC0JZ, and 0SWD0JZ
L34859	Nerve Conduction Studies and Electromyography	Added diagnosis code M62.84 for procedure codes 51785, 92265, 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95873, 95874, 95885, 95886, 95887, 95907, 95908, 95909, 95910, 95911, 95912, 95913, 95933, and 95937. Changed diagnosis code range G56.00-G56.02 to G56.00-G56.03 for procedure code 95905.
L33693	Non-Invasive Evaluation of Extremity Veins	Changed descriptor for diagnosis code range T82.817A-T82.818S for procedure codes 93965, 93970, and 93971.
L33695	Non-invasive Extracranial Arterial Studies	Added diagnosis codes I72.5, I72.6, and I77.75 for procedure codes 93880 and 93882. Removed diagnosis codes H34.811-H34.839 for procedure codes 93880 and 93882 as they are not applicable to this LCD. (Not related to ICD-10 Update) Changed diagnosis code range H34.00-H34.9 to H34.00-H34.239, and H34.9 for procedure codes 93880 and 93882.
L33696	Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries	Removed diagnosis codes I97.62 and T85.81XA for procedure codes 93922, 93923, and 93924. Changed diagnosis code range I97.610-I97.62 to I97.610-I97.618 for procedure codes 93922, 93923, and 93924.

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L33696 (cont)	Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries	Changed diagnosis code range T85.81XA-T85.9XXS to T85.810A-T85.9XXS for procedure codes 93922, 93923, and 93924. Added diagnosis codes G97.61, G97.62, H59.331-H59.339, H59.341-H59.349, I77.76, I77.77, I97.620-I97.621, I97.630-I97.638, J95.860, J95.861, K91.870, K91.871, L76.31, L76.32, M96.840, M96.841, N99.840, and N99.841 for procedure codes 93922, 93923, and 93924. Changed descriptors for diagnosis codes D78.22, G97.51-G97.52, H59.329, H95.42, I97.610-I97.618, J95.830-J95.831, K91.840-K91.841, L76.21-L76.22, M96.831, N99.820-N99.821, and T83.81XA for procedure codes 93922, 93923, and 93924.
L33705	Ocular Photodynamic Therapy (OPT) with Verteporfin	Removed diagnosis code H35.32 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes 67221, 67225, and J3396. Added diagnosis code ranges H35.3210-H35.3213, H35.3220-H35.3223, H35.3230-H35.3233, and H35.3290 - H35.3293 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes 67221, 67225, and J3396.

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LCD database ID number	LCD title	2017 changes
L33705 (cont)	Ocular Photodynamic Therapy (OPT) with Verteporfin	Removed diagnosis code H35.31 under the “ICD-10 Codes that DO NOT Support Medical Necessity” section of the LCD for procedure codes 67221, 67225, and J3396. Added diagnosis code ranges H35.3110-H35.3114, H35.3120-H35.3124, H35.3130-H35.3134, H35.3190-H35.3194 under the “ICD-10 Codes that DO NOT Support Medical Necessity” section of the LCD for procedure codes 67221, 67225, and J3396.
L34017	Ophthalmoscopy	Removed diagnosis codes E08.359, E09.359, E10.321, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.321, E13.331, E13.339, E13.341, E13.349, E13.351, and E13.359 for procedure codes 92225 and 92226. Added diagnosis code ranges E10.3211-E10.3219, E11.3211-E11.3219, E11.3291-E11.3299, and E13.3211-E13.3219 for procedure codes 92225 and 92226. Changed diagnosis code ranges E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599, diagnosis code range E10.331-E10.339 to E10.3311-E10.3399,

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L34017 (cont)	Ophthalmoscopy	diagnosis code range E10.341-E10.349 to E10.3411-E10.3499, diagnosis code range E10.351-E10.359 to E10.3511-E10.3599, diagnosis code range E11.331-E11.339 to E11.3311-E11.3399, diagnosis code range E11.341-E11.349 to E11.3411-E11.3499, diagnosis code range E11.351-E11.359 to E11.3511-E11.3599, diagnosis code range E13.331-E13.339 to E13.3311-E13.3399, diagnosis code range E13.341-E13.349 to E13.3411-E13.3499, and diagnosis code range E13.351-E13.359 to E13.3511-E13.3599 for procedure codes 92225 and 92226.
L33747	Pegfilgrastim (Neulasta®)	Added diagnosis code range C49.A0-C49.A9 for procedure code J2505.
L33252	Psychiatric Diagnostic Evaluation and Psychotherapy Services	Removed diagnosis codes F32.8, F34.8, F42, and F50.8 for procedure codes 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, and 90853. Changed diagnosis code range F32.0-F32.8 to F32.0-F32.89, diagnosis code range F34.0-F34.8 to F34.0-F34.89, diagnosis code range F42-F43.8 to F42.2-F43.8, and diagnosis code range F50.00-F50.8 to F50.00-F50.89 for procedure codes 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, and 90853.

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LCD database ID number	LCD title	2017 changes
L34520	Psychological and Neuro-psychological Tests	<p>Removed diagnosis codes I69.01, I69.11, I69.21, I69.31, I69.81, and I69.91 for procedure codes 96101, 96102, 96103, 96118, 96119, 96120, and G0451.</p> <p>Changed diagnosis code range I69.01-I69.020 to I69.010-I69.020 and diagnosis code range I69.11-I69.122 to I69.110-I69.122 for procedure codes 96101, 96102, 96103, 96118, 96119, 96120, and G0451.</p> <p>Added diagnosis code ranges I69.210-I69.219, I69.310-I69.319, I69.810-I69.819, and I69.910-I69.919 for procedure codes 96101, 96102, 96103, 96118, 96119, 96120, and G0451.</p>
L33407	Ranibizumab (Lucentis®)	<p>Removed diagnosis codes E08.321, E08.331, E08.341, E08.351, E09.321, E09.331, E09.341, E09.351, E10.321, E10.331, E10.341, E10.351, E11.321, E11.331, E11.341, E11.351, E13.321, E13.331, E13.341, E13.351, H34.811, H34.819, H34.831, H34.839, and H35.32 for procedure code J2778.</p> <p>Added diagnosis code ranges E08.3211-E08.3219, E08.3311-E08.3319, E08.3411-E08.3419, E08.3511-E08.3519, E09.3211-E09.3219, E09.3311-E09.3319, E09.3411-E09.3419, E09.3511-E09.3519, E10.3211-E10.3219,</p>

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L33407 (cont)	Ranibizumab (Lucentis®)	<p>E10.3311-E10.3319, E10.3411-E10.3419, E10.3511-E10.3519, E11.3211-E11.3219, E11.3311-E11.3319, E11.3411-E11.3419, E11.3511-E11.3519, E13.3211-E13.3219, E13.3311-E13.3319, E13.3411-E13.3419, E13.3511-E13.3519, and H35.3210-H35.3293 for procedure code J2778.</p> <p>Changed diagnosis code range H34.811-H34.819 to H34.8110-H34.8192 and diagnosis code range H34.831-H34.839 to H34.8310-H34.8392 for procedure code J2778.</p>
L33715	Renal Angiography	<p>Removed diagnosis code K55.0 for procedure codes 36251, 36252, 36253, and 36254.</p> <p>Added diagnosis code range K55.011-K55.049 for procedure codes 36251, 36252, 36253, and 36254.</p>
L33745	Respiratory Therapeutic Services	<p>Removed diagnosis code J98.5 for procedure codes G0237, G0238, and G0239.</p> <p>Changed diagnosis code range J98.5-J98.9 to J98.51-J98.9 for procedure codes G0237, G0238, and G0239.</p>
L33746	Rituximab (Rituxan®)	<p>Changed descriptor for diagnosis code range C81.40-C81.49 for procedure code J9310.</p>
L33751	Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	<p>codes E08.359, E09.359, E10.359, E11.359, E13.359, H34.811, and H34.839 under the "Limitations" section of the LCD for procedure codes 92133 and 92134.</p>

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LCD database ID number	LCD title	2017 changes
L33751 (cont)	Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	<p>Removed diagnosis codes E08.359, E09.359, E10.359, E11.359, E13.359, H34.811, H34.819, H34.831, and H34.839 under the “ICD-10 Codes that Support Medical Necessity” section of the LCD for procedure codes 92133 and 92134.</p> <p>Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599, diagnosis code range E10.311-E10.359 to E10.311-E10.3599, diagnosis code range E11.311-E11.359 to E11.311-E11.3599, diagnosis code range E13.311-E13.359 to E13.311-E13.3599, and diagnosis code range H34.811-H34.839 to H34.8110-H34.8392 under the “Limitations” section of the LCD for procedure codes 92133 and 92134.</p> <p>Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599, diagnosis code range E10.311-E10.359 to E10.311-E10.3599, diagnosis code range E11.311-E11.359 to E11.311-E11.3599, diagnosis code range E13.311-E13.359 to E13.311-E13.3599, diagnosis code range H34.811-H34.819 to H34.8110-H34.8192, and diagnosis code range H34.831-H34.839 to H34.8310-H34.8392</p>

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L33751 (cont)	Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	<p>under the “ICD-10 Codes that Support Medical Necessity” section of the LCD for procedure codes 92133 and 92134.</p> <p>Added diagnosis code ranges E08.37X1-E08.37X9, E09.37X1-E09.37X9, E10.37X1-E10.37X9, E11.37X1-E11.37X9, and E13.37X1-E13.37X9 under the “Limitations” and “ICD-10 Codes that Support Medical Necessity” sections of the LCD for procedure codes 92133 and 92134.</p> <p>Added diagnosis code Z79.84 for procedure code 92134.</p>
L34022	Serum Phosphorus	<p>Removed diagnosis code K90.4 and Z98.89 for procedure code 84100.</p> <p>Changed diagnosis code range K90.0-K90.4 to K90.0-K90.49 for procedure code 84100.</p> <p>Added diagnosis codes M62.84 and Z98.890 for procedure code 84100.</p>
L36035	Spinal Cord Stimulation for Chronic Pain	<p>Changed diagnosis code range G56.40-G56.42 to G56.40- G56.43, diagnosis code range G56.80-G56.92 to G56.80-G56.93, diagnosis code range G57.70-G57.72 to G57.70-G57.73, diagnosis code range G57.80-G57.82 to G57.80-G57.83, and diagnosis code range G57.90-G57.92 to G57.90-G57.93 for procedure codes 63650, 63655, 63661-63664, 63685, and 63688.</p>

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L36035 (cont)	Spinal Cord Stimulation for Chronic Pain	Removed diagnosis code range T85.81XA-T85.89XS for procedure codes 63650, 63655, 63661-63664, 63685, and 63688. Added diagnosis range T85.810A-T85.898S for procedure codes 63650, 63655, 63661-63664, 63685, and 63688.
L34023	Strapping	Added diagnosis code range M21.611-M21.629 for procedure codes 29540 and 29550. Added diagnosis code range S92.811A-S92.819S for procedure codes 29540, 29550, and 29580.
L34025	Surgical Decompression for Peripheral Polyneuropathy	Added diagnosis code G61.82 for procedure codes 28035, 64702, 64704, 64708, 64712, 64714, 64722, 64726 and 64727.
L33411	Surgical Management of Morbid Obesity	Removed diagnosis code E78.0 for procedure codes 43770 and 43775. Changed diagnosis code range E78.0-E78.5 to E78.00-E78.5 for procedure codes 43770 and 43775.
L33754	Syphilis Test	Removed diagnosis code F32.8 for procedure codes 86592, 86593, and 86780. Added diagnosis codes F32.81 and F32.89 for procedure codes 86592, 86593, and 86780. Changed descriptor for diagnosis code P00.2 for procedure codes 86592, 86593, and 86780.

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L33413	Therapy and Rehabilitation Services	Changed diagnosis code range G56.40-G56.42 to G56.40-G56.43, diagnosis code range G56.90-G56.92 to G56.90-G56.93, diagnosis code range G57.10-G57.12 to G57.10-G57.13, diagnosis code range G57.20-G57.22 to G57.20-G57.23, diagnosis code range G57.30-G57.32 to G57.30-G57.33, diagnosis code range G57.40-G57.42 to G57.40-G57.43, diagnosis code range G57.60-G57.62 to G57.60-G57.63, diagnosis code range G57.70-G57.72 to G57.70-G57.73, diagnosis code range G57.80-G57.82 to G57.80-G57.83 and diagnosis code range G57.90-G57.92 to G57.90-G57.93 for procedure code 97026. Added diagnosis code G61.82 for procedure code 97026. Removed diagnosis code Z98.89 for procedure code 97116. Added diagnosis code Z98.890 for procedure code 97116
L34031	Total Calcium	Removed diagnosis codes K85.0, K85.9, and K90.4 for procedure code 82310. Changed diagnosis code range K85.0-K85.9 to K85.00-K85.92 and diagnosis code range K90.0-K90.4 to K90.0-K90.49 for procedure code 82310. Added diagnosis code M62.84 for procedure code 82310.

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LCD database ID number	LCD title	2017 changes
L33756	Transesophageal Echocardiogram	<p>Removed diagnosis code Q25.2 for procedure codes 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93355, C8925, C8926, and C8927.</p> <p>Changed diagnosis code range Q20.0-Q25.2 to Q20.0-Q25.29 for procedure codes 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93355, C8925, C8926, and C8927.</p> <p>Changed descriptors for diagnosis code ranges T82.827A-T82.827S, T82.837A-T82.837S, T82.847A-T82.847S, T82.857A-T82.857S, and T82.867A-T82.867S for procedure codes 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93355, C8925, C8926, and C8927.</p>
L33768	Transthoracic Echo-cardiography (TTE)	<p>Removed diagnosis code Q25.2 for procedure codes 93306, 93307, 93308, C8923, and C8924.</p> <p>Changed diagnosis code range Q20.0-Q25.2 to Q20.0-Q25.29 for procedure codes 93306, 93307, 93308, C8923, and C8924.</p>

LCD database ID number	LCD title	2017 changes
L33768 (cont)	Transthoracic Echo-cardiography (TTE)	<p>Changed diagnosis code range I77.71-I77.79 to I77.70-I77.79 for procedure codes 93306, 93307, 93308, C8923, and C8924.</p> <p>Changed descriptors for diagnosis code ranges T82.827A-T82.827S, T82.837A-T82.837S, T82.847A-T82.847S, T82.857A-T82.857S, and T82.867A-T82.867S for procedure codes 93306, 93307, 93308, C8923, and C8924.</p>
L34001	Vinorelbine Tartrate (Navelbine®)	Added diagnosis code range C49.A0-C49.A9 for procedure code J9390.
L33766	Visual Field Examination	Changed diagnosis code range E08.311-E08.36 to E08.311-E08.37X9 and diagnosis code range E09.311-E09.36 to E09.311-E09.37X9 for procedure codes 92081, 92082, and 92083.
L33771	Vitamin D; 25 hydroxy, includes fraction(s), if performed	<p>Removed diagnosis code K90.4 for procedure code 82306.</p> <p>Changed diagnosis code range K90.0-K90.4 to K90.0-K90.49 for procedure code 82306</p>

New CERT documentation contractor effective October 14, 2016

AdvanceMed, the current comprehensive error rate testing (CERT) review contactor will also be operating the CERT documentation center, effective October 14,

2016. Beginning October 7, 2016, all CERT inquires and medical records should be sent to AdvanceMed. For more information, visit the [CERT website](#).

Upcoming provider outreach and educational events

Medicare Part A changes and regulations

Date: Tuesday, December 13

Time: 10:00 a.m.-11:30 a.m.

Type of Event: Webcast

<https://medicare.fcso.com/Events/0353837.asp>

Ask-the-contractor teleconference (ACT): Skilled nursing facility (SNF) billing and documentation requirements (Part A)

Date: Thursday, December 15

Time: 10:00 a.m.-11:30 a.m.

Type of Event: Face-to-face

<https://medicare.fcso.com/Events/0354913.asp>

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

Two easy ways to register

Online – Visit our provider training website at <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.



CMS MLN Connects® Provider eNews



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 September 29, 2016

MLN Connects® Provider eNews for September 29, 2016
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Claims, Pricers & Codes

Editor’s Note:

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. In this issue, learn about the new Medicare Beneficiary Identifier, and find out how to prepare.

News & Announcements

- Social Security Number Removal Initiative
- 2015 PQRS Feedback Reports and 2015 Annual QRURs Available
- IMPACT Act Cross-Setting Quality Measure on Major Falls: Comments due October 14
- New CERT Documentation Contractor Effective October 14
- Medicare EHR Requirements for 2016 Participation
- EHR Incentive Programs: 2016 Exclusions and Alternate Exclusions
- eCQM: Review and Comment on Proposed Specification Changes
- Updated ICD-10 Flexibility FAQs and 2017 Codes
- Medscape Article for CME Credit: Transforming Clinical Practice to Provide Patient-Centered Quality Care
- National Cholesterol Education Month and World Heart Day

Provider Compliance

- Evaluation and Management: Billing the Correct Level of Service



- Hospices: Hold on Claim Adjustments for Miscalculated Routine Home Care Days

Upcoming Events

- Emergency Preparedness Requirements Call — October 5
- IMPACT Act: Data Elements and Measure Development Call — October 13
- How to Report Across 2016 Medicare Quality Programs Call — November 1

Medicare Learning Network® Publications & Multimedia

- SNF Quality Reporting Program Webcast: Audio Recording and Transcript — New
- Dementia Care and QAPI Call: Audio Recording and Transcript — New
- PQRS Call Addendum — New
- Inpatient Psychiatric Facility Prospective Payment System Fact Sheet — Revised
- Medicare Enrollment for Physicians and Other Part B Suppliers Fact Sheet — Revised
- Medicare Enrollment for Institutional Providers Fact Sheet — Revised
- Safeguard Your Identity and Privacy Using PECOS Fact Sheet — Revised
- Revised “How to” Products Available in Hard Copy Format

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MLN Connects® Provider eNews for October 6, 2016

MLN Connects® Provider eNews for October 6, 2016

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Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our “*Website enhancements*” page. You’ll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast’s Web team.

MLN Connects® Provider eNews for October 13, 2016

MLN Connects® Provider eNews for October 13, 2016
View this edition as a PDF

News & Announcements

- New Data to Increase Transparency on Medicare Hospice Payments
- SNF Value-Based Purchasing Program: Confidential Feedback Reports Available
- IMPACT Act Cross-Setting Quality Measure on Major Falls: Comments due October 14
- EHR Incentive Programs: Review Resources on 2016 Program Requirements
- Protect Your Patients from Influenza this Season

Provider Compliance

- Reporting Fraud to the Office of the Inspector General

Upcoming Events

- CMS Rural Health Council Solutions Summit — October 19
- 2015 Supplemental QRUR Physician Feedback Program Call — October 20
- Long-Term Care Facilities: Reform of Requirements Call — October 27
- How to Report Across 2016 Medicare Quality Programs Call — November 1

MLN Connects® Provider eNews for October 20, 2016

MLN Connects® Provider eNews for October 20, 2016
View this edition as a PDF

News & Announcements

- CMS Announces New Initiative to Increase Clinician Engagement
- Medicare's Investment in Primary Care Shows Progress
- Physician Compare Preview Period Ends November 11
- Value Modifier: Informal Review Request Period Open through November 30
- 2015 Supplemental Quality and Resource Use Reports Available
- Medicare Open Enrollment Information for your Patients

Provider Compliance

- Importance of Documentation

Claims, Pricers & Codes

- October 2016 OPPS Pricer File Update

Upcoming Events

- Long-Term Care Facilities: Reform of Requirements Call — October 27

- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 2

Medicare Learning Network® Publications & Multimedia

- Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
- Learning Management and Product Ordering System FAQs Booklet — New
- SNF Value-Based Purchasing Program Call: Audio Recording and Transcript — New
- 2015 Annual QRURs Webcast: Audio Recording and Transcript — New
- Medicare Basics: Commonly Used Acronyms Educational Tool — Revised
- Preventive Services Educational Tool — Revised
- Fraud & Abuse Educational Products — Revised
- Screening Pap Tests and Pelvic Examinations Booklet — Reminder
- Give us Your Feedback

The Medicare Learning Network®, MLN Connects®, and *MLN Matters*® are registered trademarks of the U.S. Department of Health and Human Services (HHS)..

- How to Report Across 2016 Medicare Quality Programs Call — November 1
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 2
- Quality Payment Program Final Rule Call — November 15
- Home Health Quality Reporting Program Provider Training — November 16 and 17

Medicare Learning Network® Publications & Multimedia

- Provider Compliance Fact Sheets — New
- Emergency Preparedness Requirements Call: Audio Recording and Transcript — New
- Evaluation and Management Services Guide — Revised
- Hospice Payment System Booklet — Revised
- Provider Compliance Fact Sheets — Revised
- Continuing Education Credits for Web-Based Training Courses

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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