Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

January 2017

In this issue

What can SPOT do for you – eligibility and benefits information

Use eligibility and benefits to prevent denied claims

Snowbirds, splitting their year between Florida and places north, can complicate matters for providers billing Medicare for services provided to these beneficiaries. When they receive preventative services from their physicians in their summer hometowns, and then visit Florida doctors during winter months, some beneficiaries may not be eligible for services and medical tests typically covered by Medicare.

"With our snowbirds, we have to stay on top of their eligibility status," said one Medicare billing manager. "Many beneficiaries aren't aware they enrolled in a Medicare plan different from the traditional plan. They know they have Medicare and that's it. Having fast access to Medicare eligibility and secondary payer information helps us file clean, accurate claims and get reimbursed sooner."

First Coast Service Options Inc. *offers such access through SPOT* (Secure Provider Online Tool). With SPOT, providers may access Part A and Part B eligibility status as well as benefit eligibility for preventive services, deductibles, therapy caps, inpatient, hospice and home health, Medicare secondary payer (MSP), and plan coverage data categories.

Viewing preventive service information before the patient arrives

Preventive services data includes both professional and technical services along with the next eligible dates or previous date the service was provided. SPOT eligibility reports show preventive services that are gender-specific to each beneficiary. Preventive services data *viewable in SPOT* includes:

- Abdominal aortic aneurysm ultrasound screening
- Annual depression screening
- Annual wellness visit
- Bone density measurements

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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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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.

Modifications to the national coordination of benefits agreement crossover process

***Note**: This article was revised January 9, 2017, to reflect the revised change request (CR) 9681 issued January 9. In the article, references to type of bill 82x are deleted from the last paragraph of the Background section. In addition, the CR release date, transmittal number, and the web address of CR 9681 are revised. All other information remains the same. This information was previously published in the November 2016 Part A Connection, page 6.*

Provider types affected

This *MLN Matters*® article is intended for providers, including hospices, submitting institutional claims to Medicare administrative contractors (MACs) requiring coordination of benefits (COB) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9681 modifies Medicare's Part A claim processing system to, among other things:

- Always ensure that a remittance advice remark code (RARC) accompanies claim denials tied to claims adjustment reason code (CARC) 16, as required.
- Prevent duplicate entry of hospital day counts expressed as value codes (for example, value code 80, 81, 82).
- Prevent reporting of present on admission (POA) indicators on outpatient coordination of benefits (COB) facility claims.

Make sure your billing staff is aware of these changes.

Background

The Council for Affordable Quality Healthcare Committee for Operating Rules for Information Exchange (CAQH CORE) dictates which CARC and RARC combinations must be used by all covered entities in the healthcare industry. Medicare routinely reports CARCs and RARCs on Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Institute (ASC) 835 electronic remittance advice (ERA) transactions in accordance with HIPAA requirements. Medicare also includes CARCs and RARCs within HIPAA ASC 837-N claims transactions, including 837 Coordination of Benefits (COB) claims transactions. However, within 837 claims transactions, RARCs are referred to as "claim payment reason codes" and appear within the 2320 Medicare inpatient adjudication information (MIA) and Medicare outpatient adjudication information (MOA) segments.

As a result of systems issues, MACs are not always including a valid and relevant RARC in the 2320 MIA field when they deny Medicare claims. Medicare crossover claims are often being rejected by supplemental payers as a consequence. Though not the only example, this scenario seems to occur frequently when a claim service line is editing to deny with CARC code 16—"Claim lacks information or has submission/billing error(s) which is needed for adjudication....." CR 9681 will ensure that at least one informational RARC is provided to comply with HIPAA and CAHQ/CORE requirements.

The Part A system is producing instances of duplicated hospital day counts on outbound 837 institutional COB/crossover claims. CR 9681 remedies this situation. **Important**: Hospital billing staffs should avoid entering hospital day counts via direct data entry (DDE) screens.

Lastly, at present there is no editing with the Part A system to prevent the entry of a POA indicator on incoming outpatient facility claims. CR 9681 remedies this issue by returning to the provider (RTP) any outpatient claim (type of bill other than 11x, 18x, 21x, and 41x) that contains a POA indicator. **Important**: Billing vendors for hospitals should make it a practice to only include POA indicators on 11x, 18x, 21x, and 41x type of bill (TOB) claims submitted to Medicare.

Additional information

The official instruction, CR 9681, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1770OTN.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

- January 9, 2017 – This article was revised January 9, 2017, to reflect the revised CR 9681 issued January 9. In the article, references to Type of Bill 82x are deleted from the last paragraph of the *Background* section. In addition, the CR release date, transmittal number, and the web address of CR 9681 are revised.
- October 31, 2017 – Initial issuance

MLN Matters® Number: MM9681 *Revised*
Related Change Request (CR) #: CR 9681
Related CR Release Date: January 6, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R1770OTN
Implementation Date: April 3, 2017

CMS names C2C as new qualified independent contractor

The Centers for Medicare & Medicaid Services (CMS) recently awarded the qualified independent contractor (QIC) Part A East contract to C2C Innovative Solutions, Inc. (C2C). C2C will begin processing new reconsideration requests of initial Medicare claim determinations or redeterminations for Part A Medicare and Medicare Part B of A claim appeals February 14, 2017.

C2C will also be responsible for conducting expedited reconsiderations on service termination and hospital discharge reviews performed by the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations' (QIOs). C2C currently serves as the QIC responsible for processing new reconsideration requests of initial Medicare claim determinations or redeterminations for Medicare Part B.

First Coast offers *this information* about the claim appeals process. Once an initial claim determination is made, providers, participating physicians, and other suppliers have the right to appeal. Physicians and other suppliers who do not take assignment on claims have limited appeal rights.

Reconsiderations requested on or before February 13, 2017, will continue to be processed by the existing Part A East QIC, Maximus Federal Services, Inc. (Maximus). Since Maximus will be processing appeals received prior to February 14, 2017, there will be a short transition period during which both Maximus and C2C will issue decisions.

This change affects providers in Florida, Puerto Rico, and the US Virgin Islands, as well as those in the following states: Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, and Washington DC.

2016 'Medicare Part B Participating Physician and Supplier Directory'

The *Medicare Part B Participating Physician and Supplier Directory* (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing will be available no later than January 30 on the First Coast Medicare provider website at *http://medicare.fcso.com/MEDPARD/*.

Source: Pub 100-04, Transmittal 3648, CR 9794

Provider enrollment application fee amount for 2017

On November 7, the Centers for Medicare & Medicaid Services (CMS) issued a notice: Provider Enrollment Application Fee Amount for Calendar Year 2017 [CMS–6071–N].

Effective January 1, 2017, the 2017 application fee is $560 for institutional providers that are:

- Initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP);
- Revalidating their Medicare, Medicaid, or CHIP enrollment; or
- Adding a new Medicare practice location.

This fee is required with any enrollment application submitted from January 1, 2017, through December 31, 2017.

Guidelines for unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable).

Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks.

Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Source: CMS Pub. 100-06, Chapter 5, Section 410.10

Changes to the laboratory NCD edit software for April 2017

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) 9934 informs MACs about the changes that will be included in the April 2017 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

Background

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so laboratory claims subject to one of the 23 NCDs (*Medicare National Coverage Determinations Manual*, Sections 190.12-190.34, available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part3.pdf*) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, Section 120.2 of the *Medicare Claims Processing Manual*, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. This manual chapter is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf*. 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. CR 9934 lists numerous changes to the codes applicable to the various laboratory NCDs code lists for April 2017. Those changes are too numerous to repeat in this article, but the changes are detailed in the spreadsheet attachments to CR 9934.

Additional information

The official instruction, CR 9934, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3691CP.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: MM9934
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Medicare A Connection subscription

Medicare A Connection is published monthly and is available online in both English and Spanish.

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***.

April 2017 ASP drug pricing files and revision to prior files

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) 9945 provides the April 2017 quarterly update and instructs MACs to download and implement the April 2017 average sales price (ASP) drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised January 2017, October 2016, July 2016, and April 2016 ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 3, 2017, with dates of service April 1, 2017, through June 30, 2017. MACs will not search and adjust claims previously processed unless brought to their attention.

For claims with a date of service on or after January 1, 2017, and consistent with Section 5004 of the 21st Century Cures Act, which was signed into law on December 13, 2016, payment for infusion drugs furnished through a covered item of durable medical equipment (DME) will be based on Section 1847A of the Social Security Act, meaning that most of the payments will be based on the ASP of these drugs. Payment for DME infusion drugs that do not appear on the ASP drug pricing files will be determined by the MACs in accordance with the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*.

Make sure your billing staffs are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the *Medicare Claims Processing Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

The following table shows how the quarterly payment files will be applied:

Files	Effective dates of service
April 2017 ASP and ASP NOC	April 1, 2017, through June 30, 2017
January 2017 ASP and ASP NOC	January 1, 2017, through March 31, 2017
October 2016 ASP and ASP NOC	October 1, 2016, through December 31, 2016
July 2016 ASP and ASP NOC	July 1, 2016, through September 30, 2016
April 2016 ASP and ASP NOC	April 1, 2016, through June 30, 2016

Additional information

The official instruction, CR 9945, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3692CP.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/*.

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Implementation Date: April 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.

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 LCD

Dialysis (AV fistula and graft) vascular access maintenance – retired Part A/B LCD

LCD ID number: L33316 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for dialysis (AV fistula and graft) vascular access maintenance is being retired effective January 1, 2017. The following *Current Procedural Terminology* (CPT®) codes (35475, 35476, 36147, 36148, and 36870) have been deleted and replaced with new CPT® codes (36901-36909) that address this episode of care. Absent an LCD, assuming all other requirements of the program are met, the medically reasonable and necessary threshold for coverage applies for these procedures including qualifications of the performing provider.

Effective date

This LCD retirement is effective for services rendered **on or after January 1, 2017**. 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*.

Revisions to LCDs

Intravenous Immune Globulin – revision to the Part A and Part B LCD

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

Based on a reconsideration request to include a diagnosis code for antibody mediated rejection (AMR) post kidney transplant, the local coverage determination (LCD) for intravenous immune globulin was revised to add ICD-10-CM diagnosis code T86.11 (kidney transplant rejection) to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after January 17, 2017**. 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*.

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.

Ophthalmoscopy – revision to the Part A and Part B LCD

LCD ID number: L34017 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a request to include a diagnosis code range for the local coverage determination (LCD) for Ophthalmoscopy, the LCD was revised to include ICD-10 code range E10.3291–E10.3299 (diabetes Mellitus with mild non-proliferative diabetic retinopathy without macular edema) 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 January 9, 2017**, for services rendered **on or after October 1, 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*.

Rituximab (Rituxan®) – revision to the Part A and Part B LCD

LCD ID number: L33746 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request to include a diagnosis code for antibody mediated rejection (AMR) post kidney transplant, the local coverage determination (LCD) for rituximab (Rituxan®) was revised to add ICD-10-CM diagnosis code T86.11 (kidney transplant rejection) to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after January 17, 2017**. 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*.

Therapy and Rehabilitation Services – revision to the Part A and Part B LCD

LCD ID number: L33413 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 9861, ICD-10 Coding Revisions to National Coverage Determination (NCDs), the Centers for Medicare & Medicaid Services (CMS) has instructed contractors to remove all associated diagnosis codes in current editing for *Current Procedural Terminology* (CPT®) code 97026 (application of a modality to 1 or more areas; infrared) effective October 1, 2015, as infrared therapy is noncovered for all indications. Therefore, the local coverage determination (LCD) for therapy and rehabilitation services was revised to remove all associated language and diagnosis codes for CPT® code 97026 as infrared therapy is noncovered for all indications.

Effective date

This LCD revision is effective for claims processed **on or after January 20, 2017**, for services rendered **on or after October 1, 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*.

January 2017 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 & hospice (HH&H) MACs for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed

This article is based on change request (CR) 9930 which describes changes to the OPPS to be implemented in the January 2017 update. Make sure your billing staffs are aware of these changes.

Background

Change request (CR) 9930 describes changes and billing instructions for various payment policies being implemented in the January 2017 OPPS update. The January 2017 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 9930.

Key changes in CR 9930

Key changes to and billing instructions for various payment policies implemented in the January 2017 OPPS updates are as follows:

New Device Pass-Through Policies

a. New Device Pass-Through Categories

The Social Security Act (*Section 1833(t)(6)(B)*) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Social Security Act requires that the Centers for Medicare & Medicaid Services (CMS) create additional categories for transitional pass-through payment of new medical devices that are not described by existing or previously existing categories of devices.

b. Policy

In the 2017 outpatient prospective payment system/ ambulatory surgical center (OPPS/ASC) final rule with comment period that was published in the *Federal Register* November 14, 2016, CMS adopted a policy to revise the pass-through payment time period by having the pass-through start date begin with the date of first payment and by allowing pass-through status to expire on a quarterly basis, such that the duration of device pass-through payment will be as close to 3 years as possible.

In addition, in calculating the pass-through payment, the "Implantable Devices Charged to Patients Cost-to-Charge Ratio (CCR)" will replace the hospital-specific CCR, when available and device offsets will be calculated from the HCPCS payment rate, instead of the APC payment rate (81 FR 79655 through 79657). Refer to the *CY 2017 OPPS/ASC final rule with comment period* for complete details of these policy changes for device pass-through that will become effective on January 1, 2017. Effective January 1, 2017, there are three device categories eligible for pass-through payment: (1) HCPCS code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser); (2) HCPCS code C2613 (Lung biopsy plug with delivery system); and (3) HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system). Also, refer to *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html* for the most current device pass-through information.

c. Transitional pass-through payments for designated devices

Certain designated new devices are assigned to APCs and identified by the OCE as eligible for payment based on the reasonable cost of the new device, reduced by the amount included in the APC for the procedure that reflects the packaged payment for device(s) used in the procedure. OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device. Refer to *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html* for the most current OPPS HCPCS Offset File.

Device intensive procedures

Effective January 1, 2017, CMS will assign device-intensive status at the HCPCS code level for all procedures requiring the implantation of a medical device, in which the individual HCPCS level device offset is greater than 40 percent. All new procedures requiring the insertion of an implantable medical device will be assigned a default device offset percentage of at least 41 percent, and be assigned device intensive status, until claim data is available. In certain rare instances, CMS may temporarily assign a higher offset percentage, if warranted, with additional information. Effective January 1, 2017, CMS will no longer assign device-intensive status based upon the APC level device offset percentage.

In light of this policy change, CMS is modifying Sections 20.6.4 and 61.2 of Chapter 4 of the *Medical Claims Processing Manual*.

Argus retinal prosthesis add-on code (C1842)

Effective January 1, 2017, CMS is creating HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add-on to C1841) and assigning it a status indicator (SI) of N. HCPCS code C1842 was created to resolve a claim processing issue for ASCs and should not be reported on institutional claims by hospital outpatient department providers.

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OPPS

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Additionally, although HCPCS code C1842 was not included in the 2017 annual HCPCS file, the code has been included in the January 2017 I/OCE. Therefore, MACs will add this code to their HCPCS system.

Services eligible for new technology APC assignment and payments

Under OPPS, services eligible for payment through new technology APCs are those codes that are assigned to the series of new technology APCs published in Addendum A of the latest OPPS update. OPPS considers any HCPCS code assigned to the APCs below to be a "new technology procedure or service." As of January 1, 2017, the range of new technology APCs include:

- APCs 1491 through 1500
- APCs 1502 through 1537
- APCs 1539 through 1585
- APCs 1589 through 1599
- APCs 1901 through 1906

The application for consideration as a new technology procedure or service is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html*. Under the *Downloads* section, refer to the document titled *For a New Technology Ambulatory Payment Classification (APC) Designation Under the Hospital Outpatient Prospective Payment System (OPPS)* for information on the requirements for submitting an application.

The list of HCPCS codes and payment rates assigned to new technology APCs are in Addendum B of the latest OPPS update regulation each year at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Expiration of modifier 'L1' for unrelated lab tests in the OPPS

As a result of the 2014 OPPS policy to package laboratory services in the hospital outpatient setting, the "L1" modifier was used on type of bill (TOB) 13x to identify unrelated laboratory tests that were ordered for a different diagnosis and by a different practitioner than the other OPPS services on the claim.

In the 2016 OPPS final rule, CMS established status indicator "Q4," which conditionally packaged clinical diagnostic laboratory services. Status indicator "Q4" designates packaged APC payment when billed on the same claim as a HCPCS code assigned status indicator "J1," "J2," "S," "T," "V," "Q1," "Q2," or "Q3". The "Q4" status indicator was created to identify 13x bill type claims where there are only laboratory HCPCS codes that appear on the clinical laboratory fee schedule (CLFS); to automatically change their status indicator to "A"; and to pay them separately at the CLFS payment rates. In the 2017 OPPS/ASC final rule with comment period, CMS finalized a policy to eliminate the L1 modifier. Beginning January 1, 2017, CMS is discontinuing the use of the "L1" modifier to identify unrelated laboratory tests on claims.

Conditional packaging change to apply at claim level

When conditional packaging was initially adopted under the OPPS, it was based on the date of service associated with other items and services furnished on the claim. When CMS established the comprehensive APCs in the 2015 OPPS, packaging was applied on a claim basis. To promote consistency and ensure appropriate packaging under OPPS policy, CMS finalized a change in the 2017 OPPS to apply conditional packaging for status indicators "Q1" and "Q2" on a claim basis.

Exception for laboratory packaging in the OPPS for advanced diagnostic laboratory tests (ADLTs)

Beginning in the 2014 OPPS, CMS established that laboratory tests for molecular pathology tests described by *Current Procedural Terminology* (CPT®) codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 are not packaged in the OPPS.

In the 2017 OPPS, CMS is expanding the laboratory packaging exclusion that currently applies to molecular pathology tests (described by CPT® codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479) to all laboratory tests designated as advanced diagnostic laboratory tests (ADLTs) that meet the criteria of the Social Security Act (*Section 1834A(d)(5)(A)*).

FX modifier (X-ray taken using film)

In accordance with provisions allowed under Section 1833(t)(16)(F)(iv) of the Social Security Act, CMS has established a new modifier "FX" to identify imaging services that are X-rays taken using film. Effective January 1, 2017, hospitals are required to use this modifier on claims for imaging services that are X-rays.

The use of this modifier will result in a payment reduction of 20 percent in 2017 for the X-ray services taken using film when the service is paid separately. The use of the FX modifier and subsequent reduction in payment under the OPPS is applicable to all imaging services that are X-rays taken using film. All imaging services that are X-rays are listed in Addendum B of the *2017 OPPS/ASC final rule*. CMS is updating the *Medicare Claims Processing Manual*, Chapter 4, Section 20.6.13, to include this new modifier.

Computed tomography (CT) modifier ('Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR–29–2013 standard')

In accordance with the Social Security Act (Section 1834(p)), CMS established modifier "CT", effective January 1, 2016, to identify CT scans that are furnished on equipment that does not meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, titled *Standard Attributes on CT Equipment Related to Dose Optimization and Management*. Hospitals are required to use this modifier on claims for CT scans

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on non-NEMA standard XR-29-2013-compliant equipment. The applicable CT services are identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 73700 through 73706; 74150 through 74178; 74261 through 74263; and 75571 through 75574 (and any succeeding codes).

Effective January 1, 2017, the use of this modifier will result in a payment reduction of 15 percent for the applicable CT services when the service is paid separately. The 15 percent payment reduction will also be applied to the APC payment for the HCPCS codes listed above that are subject to the multiple imaging composite policy. This includes procedures assigned to the two APCs (8005 and 8006) in the CT and CT angiography (CTA) imaging family.

Billing for items and services furnished at off-campus hospital outpatient departments

In accordance with the Social Security Act (Section 1833(t)(21)), as added by Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS has established a new modifier "PN" (Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital) to identify and pay nonexcepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line for non-excepted items and services. The use of modifier "PN" will trigger a payment rate under the Medicare physician fee schedule. CMS expects the PN modifier to be reported with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO" (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services furnished. Use of the off-campus provider-based department (PBD) modifier became mandatory beginning January 1, 2016.

CMS would not expect off-campus PBDs to report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a nonexcepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the nonexcepted claim lines.

Neither the PO nor the PN modifier is to be reported by the following hospital departments:

- A dedicated emergency department as defined in existing regulations at *42 CFR 489.24(b)*
- A PBD that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital as defined under *42 CFR 413.65*

Partial hospitalization program (PHP)

a. Update to PHP per diem costs

The 2017 OPPS/ASC final rule with comment period replaces the existing two-tiered APC structure for PHPs with a single APC by provider type for providing three or more services per day. Specifically, CMS is replacing existing community mental health center (CMHC) APCs 5851 (Level 1 Partial Hospitalization (three services)) and 5852 (Level 2 partial hospitalization (four or more services)) with a new CMHC APC 5853 (Partial hospitalization (three or more services per day)), and replacing existing hospital-based PHP APCs 5861 (Level 1 partial hospitalization (three services)) and 5862 (level 2 partial hospitalization (four or more services)) with a new hospital−based PHP APC 5863 (Partial hospitalization (three or more services per day)).

b. CMHC provider-level outlier cap

The 2017 OPPS/ASC final rule with comment period implements a CMHC outlier payment cap to be applied at the provider level. In any given year, an individual CMHC will receive no more than 8 percent of its CMHC total per diem payments in outlier payments. The provider-level cap on CMHC outlier payments would be managed by the claim processing system. The existing outlier reconciliation process remains in place to adjust outlier payments at final cost report settlement, based on changes in the provider's CCR.

c. PHP payments under Section 603 (off-campus policy)

The Social Security Act (Section 1861(ff)(3)(A)) specifies that a PHP is a program furnished by a hospital, to its outpatients, or by a CMHC. The Social Security Act (Section 1833(t)(1)(B)(i)) provides the Secretary with the authority to designate the outpatient department services to be covered under the OPPS. As a part of the OPPS, hospital-based (HB), PHPs are affected by this new legislation. CMHCs are not affected because they are not a hospital or a department/unit of a hospital. The 2017 OPPS/ASC final rule with comment adopts payment for non-excepted hospital-based PHPs under the MPFS, paying the CMHC per diem rate for APC 5853, for providing three or more PHP services per day.

Changes to policies related to allogeneic hematopoietic stem cell transplantation (HSCT)

a. Allogeneic hematopoietic stem cell transplantation (HSCT) (C-APC 5244)

Effective January 1, 2017, CMS is assigning procedures described by CPT® code 38240 (Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor) to newly established comprehensive APC (C-APC) 5244 (Level 4 blood product exchange and related services). CPT® code 38240 will be assigned status indicator "J1". The assignment of CPT® code 38240 to C-APC 5244 and status indicator "J1" will allow for all other OPPS payable services and items reported on the claim (including donor acquisition costs) to be deemed adjunctive services representing components of a comprehensive service and result in a single prospective payment through C-APC

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5244 for the comprehensive service based on the costs of all reported services on the claim.

b. New revenue code 0815 for allogeneic stem cell acquisition services

Effective January 1, 2017, hospitals are required to report revenue code 0815 when billing donor acquisition costs associated with allogeneic hematopoietic stem cell transplantation (HSCT). CMS is also implementing a code edit (edit 100) effective January 1, 2017, that will require donor acquisition charges for allogeneic HSCT reported with revenue code 0815 to be included on a claim with CPT® code 38240 (Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor). Donor acquisition charges for allogeneic HSCT are described in the *Medicare Claims Processing Manual*, Chapter 4, Section 231.11. Revenue code 0819 is no longer required for the reporting of donor acquisition charges for allogeneic HSCT. CMS is updating the *Medicare Claims Processing Manual*, Chapter 4, Section 231.11 and Chapter 3, Section 90.3.1 to reflect the new billing guidelines for allogeneic HSCT.

Drugs, biologicals, and radiopharmaceuticals

a. New 2017 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For 2017, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 1 below.

Table 1 − New 2017 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

2017 code	2017 long descriptor	2017 SI	2017 APC
90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	L	
90750	Zoster (shingles) vaccine (HZV), recombinant, sub-unit, adjuvanted, for intramuscular injection	E1	
A9587	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie	G	9056
A9588	Fluciciovine f-18, diagnostic, 1 millicurie	G	9052
A9597	Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified	N	
A9598	Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified	N	
C9140	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.	G	9043
J0570	Buprenorphine implant, 74.2 mg	G	9058
J1130	Injection, diclofenac sodium, 0.5 mg	E2	
J7175	Injection, factor x, (human), 1 i.u.	K	1857
J7179	Injection, von willebrand factor (recombinant), (Vonvendi), 1 i.u. vwf:rco	G	9059
J9034	Injection, bendamustine hcl (Bendeka), 1 mg	G	1861
Q4166	Cytal, per square centimeter	N	
Q4167	Truskin, per square centimeter	N	
Q4168	Amnioband, 1 mg	N	
Q4169	Artacent wound, per square centimenter	N	
Q4170	Cygnus, per square centimenter	N	
Q4171	Interfyl, 1 mg	N	
Q4173	Palingen or palingen xplus, per square centimenter	N	
Q4174	Palingen or promatrx, 0.36 mg per 0.25 cc	N	
Q4175	Miroderm, per square centimeter	N	

b. Other changes to 2017 HCPCS and CPT® codes for certain drugs, biologicals, and radiopharmaceuticals

Many HCPCS and CPT® codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT® code descriptors that will be effective in 2017. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2016, and replaced with permanent HCPCS codes in 2017. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active 2017 HCPCS and CPT® codes.

Table 2 notes the drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT® code, its long descriptor, or both. Each product's 2016 HCPCS/CPT® code and long descriptor are noted in the two left hand columns. The 2017 HCPCS/

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CPT® code and long descriptor are noted in the adjacent right hand columns.

Table 2 − Other 2017 HCPCS and CPT® code changes for certain drugs, biologicals, and radiopharmaceuticals

2016 code	2016 long descriptor	2017 code	2017 long descriptor
C9461	Choline C 11, diagnostic, per study dose	A9515	Choline c-11, diagnostic, per study dose up to 20 millicuries
A9599	Radio-pharmaceutical, diagnostic, for beta-amyloid positron emission tomography (pet) imaging, per study dose	A9599	Radio-pharmaceutical, diagnostic, for beta-amyloid positron emission tomography (pet) imaging, per study dose, not otherwise specified
C9121	Injection, argatroban, per 5 mg	J0883	Injection, argatroban, 1 mg (for non-esrd use)
C9121	Injection, argatroban, per 5 mg	J0884	Injection, argatroban, 1 mg (for esrd on dialysis)
C9137	Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.	J7207	Injection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u.
C9138	Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U.	J7209	Injection, factor viii, (antihemophilic factor, recombinant), (nuwiq), 1 i.u.
C9139	Injection, factor ix, albumin fusion protein (recombinant), idelvion, 1 i.u.	J7202	Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u.
C9349	Puraply, and puraply antimicrobial, any type, per square centimeter	Q4172	Puraply or puraply am, per square centimeter
C9470	Injection, aripiprazole lauroxil, 1 mg	J1942	Injection, aripiprazole lauroxil, 1 mg
C9471	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	J7322	Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg
C9472	Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)	J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units
C9473	Injection, mepolizumab, 1 mg	J2182	Injection, mepolizumab, 1 mg
C9474	Injection, irinotecan liposome, 1 mg	J9205	Injection, irinotecan liposome, 1 mg
C9475	Injection, necitumumab, 1 mg	J9295	Injection, necitumumab, 1 mg
C9476	Injection, daratumumab, 10 mg	J9145	Injection, daratumumab, 10 mg
C9477	Injection, elotuzumab, 1 mg	J9176	Injection, elotuzumab, 1 mg
C9478	Injection, sebelipase alfa, 1 mg	J2840	Injection, sebelipase alfa, 1 mg
C9479	Instillation, ciprofloxacin otic suspension, 6 mg	J7342	Installation, ciprofloxacin otic suspension, 6 mg
C9480	Injection, trabectedin, 0.1 mg	J9352	Injection, trabectedin, 0.1 mg
C9481	Injection, reslizumab, 1 mg	J2786	Injection, reslizumab, 1 mg
J0571	Buprenorphine, oral, 1 mg	J0571	Buprenorphine oral 1 mg
J0573	Buprenorphine/ naloxone, oral, greater than 3 mg, but less than or equal to 3.1 to 6 mg	J0573	Buprenorphine/ naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine

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2016 code	2016 long descriptor	2017 code	2017 long descriptor
J3357	Injection, ustekinumab, 1 mg	J3357	Ustekinumab, for subcutaneous injection, 1 mg
J1745	Injection, infliximab, 10 mg	J1745	Injection, infliximab, excludes biosimilar, 10 mg
J7201	Injection, factor ix, fc fusion protein (recombinant), per iu	J7201	Injection, factor ix, fc fusion protein (recombinant), Alprolix, per iu
J7340	Carbidopa 5 mg/ levodopa 20 mg enteral suspension	J7340	Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml
Q9981	Rolapitant, oral, 1 mg	J8670	Rolapitant, oral, 1 mg
Q4105	Integra dermal regeneration template (drt), per square centimeter	Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter
Q4131	Epifix, per square centimeter	Q4131	Epifix or epicord, per square centimeter
Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)	Q2039	Influenza virus vaccine, not otherwise specified

c. Drugs and biologicals with payments based on average sales price (ASP) effective January 1, 2017

For 2017, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals continues to be made at a single rate of ASP plus 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, in 2017, a single payment of ASP plus 6 percent continues to be made for pass-through drugs, biologicals and radiopharmaceuticals 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. Effective January 1, 2017, payment rates for many drugs and biologicals have changed from the values published in the 2017 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of 2016. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2017 fiscal intermediary standard release. CMS is not publishing the updated payment rates in this CR implementing the January 2017 update of the OPPS. However, the updated payment rates effective January 1, 2017, are available in the January 2017 update of the OPPS Addendum A and Addendum B at *https://www.cms.gov/HospitalOutpatientPPS/*.

d. Drugs and biologicals based on ASP methodology with restated payment rates

Some drugs and biologicals based on 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-ServicePayment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html*. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

e. Biosimilar biological product payment policy

Effective January 1, 2017, the payment rate for a biosimilar biological product under the OPPS will continue to be the same as the payment rate in the physician office setting, (that is, calculated as the ASP of the biosimilar(s) described by the HCPCS code plus 6 percent of the ASP of the reference product). Biosimilar biological products are also be eligible for transitional pass-through payment; however, pass-through payment will be made to the first eligible biosimilar biological product to a reference product. Subsequent biosimilar biological products to a reference product will not meet the newness criterion, and therefore, will be ineligible for pass-through payment.

As a reminder, OPPS claims for separately paid biosimilar biological products are required to include a modifier (see Table 3 page 20) that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers.

f. Billing and payment for new drugs, biologicals, or radiopharmaceuticals approved by the Food and Drug Administration (FDA) but before assignment of a product-specific HCPCS code

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Hospital outpatient departments are allowed to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals that are approved by the FDA on or after January 1, 2004, for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the "unclassified" drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs, biologicals, and therapeutic radiopharmaceuticals that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under the OPPS unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, should be billed with the appropriate "A" NOC code as described below.

1. **Diagnostic radiopharmaceuticals** – All new diagnostic radiopharmaceuticals are assigned to either HCPCS code A9597 (Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified), HCPCS code A9598 (Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified), HCPCS code A9599 (Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (PET) imaging, per study dose), or HCPCS code J3490 (Unclassified drugs) (applicable to all new diagnostic radiopharmaceuticals used in non-beta-amyloid PET imaging). HCPCS code A9597, A9598, A9599, or J3490, whichever is applicable, should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS codes A9597, A9598, A9599, and J3490 are assigned status indicator "N" and, therefore, the payment for a diagnostic radiopharmaceutical assigned to any of these HCPCS codes is packaged into the payment for the associated service.
2. **Contrast agents** – All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator "N" and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.

g. Skin substitute procedure edits

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 4 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. CMS will implement an OPPS edit that requires hospitals to report all high-cost skin substitute products in combination with one of the skin application procedures described by CPT® codes 15271-15278 and to report all low-cost skin substitute products in combination with one of the skin application procedures described by HCPCS codes C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT® codes 15271-15278.

Table 4 – Skin substitute product assignment to high cost/low cost status for 2016

HCPCS code	2017 short descriptor	2017 SI	Low/high cost skin substitute
C9363	Integra meshed bil wound mat	N	High
Q4100	Skin substitute, NOS	N	Low
Q4101	Apligraf	N	High
Q4102	Oasis wound matrix	N	Low
Q4103	Oasis burn matrix	N	High
Q4104	Integra BMWD	N	High
Q4105	Integra DRT	N	High
Q4106	Dermagraft	N	High
Q4107	GraftJacket	N	High
Q4108	Integra matrix	N	High
Q4110	Primatrix	N	High
Q4111	Gammagraft	N	Low
Q4115	Alloskin	N	Low
Q4116	Alloderm	N	High
Q4117	Hyalomatrix	N	Low
Q4121	Theraskin	N	High
Q4122	Dermacell	N	High
Q4123	Alloskin	N	High
Q4124	Oasis tri-layer wound matrix	N	Low
Q4126	Memoderm/derma/ tranz/integup	N	High
Q4127	Talymed	N	High

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HCPCS code	2017 short descriptor	2017 SI	Low/high cost skin substitute
Q4128	Flexhd/ Allopatchhd/ Matrixhd	N	High
Q4131	Epifix	N	High
Q4132	Grafix core	N	High
Q4133	Grafix prime	N	High
Q4134	hMatrix	N	Low
Q4135	Mediskin	N	Low
Q4136	Ezderm	N	Low
Q4137	Amnioexcel or biodexcel, 1cm	N	High
Q4138	Biodfence dryflex, 1cm	N	High
Q4140	Biodfence 1cm	N	High
Q4141	Alloskin ac, 1cm	N	High
Q4143*	Repriza, 1cm	N	High
Q4146*	Tensix, 1cm	N	High
Q4147	Architect ecm, 1cm	N	High
Q4148	Neox 1k, 1cm	N	High
Q4150	Allowrap DS or dry 1 sq cm	N	High
Q4151	AmnioBand, guardian 1 sq cm	N	High
Q4152	Dermapure 1 square cm	N	High
Q4153	Dermavest 1 square cm	N	High
Q4154	Biovance 1 square cm	N	High
Q4156	Neox 100 1 square cm	N	High
Q4157*	Revitalon 1 square cm	N	High
Q4158*	MariGen 1 square cm	N	High
Q4159	Affinity 1 square cm	N	High
Q4160	NuShield 1 square cm	N	High
Q4161	Bio-Connekt per square cm	N	Low
Q4162	Amnio bio and woundex flow	N	Low
Q4163*	Amnion bio and woundex sq cm	N	High
Q4164	Helicoll, per square cm	N	High
Q4165	Keramatrix, per square cm	N	Low
Q4166*	Cytal, per square cm	N	Low
Q4167*	Truskin, per square cm	N	Low
Q4168*	Amnioband, 1 mg	N	Low
Q4169*	Artacent wound, per square cm	N	Low
Q4170*	Cygnus, per square cm	N	Low
Q4171*	Interfyl, 1 mg	N	Low
Q4172	PuraPly, puraply antimic	G	High
Q4173*	Palingen or palingen xplus, per sq cm	N	Low
Q4175*	Miroderm, per square cm	N	Low

*HCPCS codes Q4166, Q4167, Q4168, Q4169, Q4170, Q4171, Q4173, and Q4175 were assigned to the low cost group in the 2017 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4143, Q4146, Q4157, Q4158, and Q4163 are assigned to the high cost group for 2017.

h. Reassignment of skin substitute products from the low cost group to the high cost group – retroactive change

One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The start date on this change is retroactive to October 1, 2016. The product is listed in Table 5.

Table 5 – Updated skin substitute product assignment to high cost status retroactive to October 1, 2016

HCPCS code	Short descriptor	Status indicator	Low/high cost status
Q4158	MariGen 1 square cm	N	High

Changes to OPPS pricer logic

a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive an additional 7.1 percent payment for most services in 2017. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items, and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with the Social Security Act (Section 1833(t)(13)(B)), as added by Section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

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b. New OPPS payment rates and copayment amounts will be effective January 1, 2017. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the 2017 inpatient deductible of $1,316. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2017. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. The fixed-dollar threshold for OPPS outlier payments increases in 2017 relative to 2016. The estimated cost of a service must be greater than the APC payment amount plus $3,825 in order to qualify for outlier payments.

e. For outliers for CMHCs (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2017. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 5853 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 5853 payment x 3.4))/2.

f. Continuing CMS established policy for 2017, the OPPS pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet its hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

g. Effective January 1, 2017, CMS is adopting the FY 2017 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

h. Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), a device offset cap will be applied based on the credit amount listed in the “FD” (Credit received from the manufacturer for a replaced medical device) value code. The credit amount in value code “FD”, which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

i. Effective January 1, 2017 conditional packaging for status indicators “Q1” and “Q2” will apply at the claim level rather than the date-of-service level.

j. The payment rate field in the pricer file will be expanded from seven digits to eight digits to accommodate APC payment rates greater than or equal to $100,000.

Update the outpatient provider specific file (OPSF) for new core-based statistical area (CBSA) and wage indices for non-IPPS hospitals eligible for the out-commuting adjustment authorized by Section 505 of the MMA

CR 9930 provides instructions to the MACs for updating the OPSF, effective 2017. This includes updating the CBSA in the provider records, as well as updating the “special wage index” value for those providers who qualify for the Section 505 adjustment as annotated in Table 6 in Attachment A of CR 9930.

Note: Although the Section 505 adjustment is static for each qualifying county for three years, the special wage index will need to be updated (using the final wage index in Table 6, Attachment A in CR 9930) because the post-reclassification CBSA wage index has changed. Also, note that payment for distinct part units (DPUs) located in an acute care hospital is based on the wage index for the labor market area where the hospital is located, even if the hospital has a reclassified wage index. If the DPU falls in a CBSA eligible to receive the Section 505 out-commuting adjustment, the DPU’s final wage index should consist of the geographic wage index plus the appropriate out-commuting adjustment.

a) Updating the OPSF for expiration of transitional outpatient payments (TOPs)

Cancer and children’s hospitals are held harmless under the Social Security Act (Section 1833(t)(7)(D)(ii)) and continue to receive hold harmless TOPs permanently. For 2017, cancer hospitals will continue to receive an additional payment adjustment.

b) Updating the OPSF for the hospital outpatient quality reporting (HOQR) program requirements

Effective for OPPS services furnished on or after January 1, 2009, Subsection (d) hospitals that have failed to submit timely hospital outpatient quality data as required in the Social Security Act (Section 1833(t)(17)(A)) will receive payment under the OPPS that reflects a 2 percentage point deduction from the annual OPPS update for failure to meet the HOQR program requirements. This reduction will not apply to hospitals not required to submit quality data or hospitals that are not paid under the OPPS.

c) Updating the OPSF for the outpatient CCR

As stated in Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 50.1, MACs must maintain the accuracy of the data and update the OPSF as changes occur in data element values, including changes to provider CCRs. The file of OPPS hospital upper limit CCRs and the file of statewide CCRs are available at *www.cms.gov/HospitalOutpatientPPS/* under *Annual Policy Files*.

d) Application of the out migration adjustment for IPPS hospitals that also receive OPPS payment

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CR 9930 provides instructions to the MACs regarding the application of the out migration adjustment for hospitals located in a county eligible for the out migration adjustment, if the hospital is **not** located in a rural county deemed as a Lugar county (only applicable to 1886(d) hospitals), or the hospital has NOT been approved to reclassify as rural under Section 1886(d)(8)(E) of the Social Security Act (*42 CFR 412.103*), or the hospital does NOT have an MGCRB reclassification.

Note: Hospitals that are LUGAR (and did not waive its LUGAR status) or qualify for MGCRB or 412.103 reclassification are not eligible for the out migration adjustment.

e) Updating the OPSF for hospitals reclassified as rural hospitals under Section 412.103 and hospitals reclassified under the Medicare Geographic Classification Review Board (MGCRB)

An urban hospital that reclassifies as a rural hospital under Section 412.103 is considered rural for all OPPS purposes. Prior to April 21, 2016, the regulations at Section 412.230(a)(5)(ii) and Section 412.230(a)(5)(iii) prohibited hospitals from simultaneously receiving an urban to rural reclassification under Section 412.103 and a reclassification under the MGCRB. Also, the regulations did not allow a LUGAR hospital to keep its LUGAR status if it was approved for an urban to rural reclassification under Section 412.103. The court decisions in Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services, 794 F.3d 383 (3d Cir. 2015) and Lawrence + Memorial Hospital v. Burwell, No. 15-164, 2016 WL 423702 (2d Cir. Feb. 4, 2015) ruled as unlawful the regulation precluding a hospital from maintaining simultaneous MGCRB and Section 412.103 reclassifications.

Therefore, on April 18, 2016, CMS issued an interim final rule with comment period (CMS-1664-IFC) amending the regulations to conform to the court decisions. The IFC is effective April 21, 2016, and was finalized on August 2, 2016. The IFC allows hospitals nationwide that have an MGCRB reclassification or LUGAR status during FY 2016 and subsequent years the opportunity to simultaneously seek urban to rural reclassification under Section 412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or LUGAR status.

At any point during a calendar year, MACs may be notified by the CMS Regional Offices of hospitals located in an urban CBSA that are approved to reclassify as rural under Section 1886(d)(8)(E) of the Social Security Act (Section 412.103). The regulations at Section 412.103(a)(c) provide the CMS Regional Offices with up to 60 days to review and approve an urban to rural reclassification request. If the request is approved by CMS regional office, the approval is effective as of the filing date of the request (typically specified in the CMS regional office's approval letter).

Instructions for updating the OPSF if a hospital is approved for an urban to rural reclassification under Section 1886(d)(8)(E) of the Social Security Act (§ 412.103) with an effective date of April 21, 2016, and after for 2016

CR 9930 provides instruction to MACs for updating the OPSF when a hospital is approved for an urban to rural reclassification under Section 1886(d)(8)(E) of the Social Security Act (Section 412.103) with an effective date of April 21, 2016, and after for 2016.

Instructions for updating the OPSF for treatment of certain urban hospitals reclassified as rural hospitals under Section 412.103 in 2017 but with no other reclassifications

An urban hospital that reclassifies as a rural hospital under Section 412.103 is considered rural. In order to ensure correct payment under the OPPS, the rural CBSA (two-digit state code) in the wage index location CBSA and the special payment indicator field must be updated. CR 9930 provides instructions to MACs to make that update.

Instructions for updating the OPSF if a hospital is approved for an urban to rural reclassification under Section 1886(d)(8)(E) of the Social Security Act (Section 412.103) with an effective date of January 1, 2017, and after for 2017

CR 9930 provides instructions to the MACS for updating the OPSF using Table 7 in the attachment to CR 9930.

Instructions for updating the OPSF if a hospital cancels an urban to rural reclassification under Section 1886(d)(8)(E) of the Social Security Act (Section 412.103)

For a hospital that notifies the CMS regional office that it wishes to cancel its urban to rural reclassification under Section 1886(d)(8)(E) of the Social Security Act (42 CFR 412.103), CR 9930 provides instructions to the MACS for updating its OPSF.

CR 9930 also provides instructions to the MACs for updating the OPSF for hospitals that have both a MGCRB reclassification/LUGAR status and a Section 412.103 urban to rural reclassification and cancel its urban to rural reclassification under Section 1886 (d)(8)(E) of the Social Security Act (412.103) in the middle of the fiscal year.

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. Medicare administrative contractors (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

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2017 annual update of clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

Provider types affected

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

Provider action needed

Change request (CR) 9909 provides instructions for the 2017 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. This update applies to Chapter 16, Section 20 of the *Medicare Claims Processing Manual*.

Background

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), the annual update to the local clinical laboratory fees for 2017 is 0.70 percent. The annual update to payments made on a reasonable charge basis for all other laboratory services for 2017 is 1.00 percent (See 42 CFR 405.509(b)(1)).

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key points of CR 9909

National minimum payment amounts

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

The 2017 national minimum payment amount is $14.49 ($14.39 times 0.70 percent update for 2017). The affected codes for the national minimum payment amount are *Current Procedural Terminology* (CPT®) 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, G0476, and P3000.

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Additional information

The official instructions, CR 9930, issued to your MAC regarding this change are available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3685CP.pdf* and *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R232BP.pdf*.

You may refer to *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html* for the most current OPPS HCPCS offset file.

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/*.

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Implementation Date: January 3, 2017

Table 3 – Biosimilar biological product payment and required modifiers

HCPCS code	Short descriptor	Long descriptor	SI	APC	HCPCS code effective date	HCPCS modifier	HCPCS modifier effective date
Q5101	Inj filgrascsf biosimtim g-	Injection, filgrastim (G-CSF), biosimilar, 1 microgram	G	1822	3/6/15	ZA-Novartis/ Sandoz	01/01/2016
Q5102	Inj., infliximab biosimilar	Injection, Infliximab, Biosimilar, 10 mg	K	1847	4/5/16	ZB-Pfizer/ Hospira	04/01/2016

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National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

Access to data file

Internet access to the 2017 clinical laboratory fee schedule data file will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Other interested parties, such as the Medicaid state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the internet to retrieve the 2017 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Data file format

For each test code, if your system retains only the pricing amount, load the data from the field named “60% Pricing Amt.” For each test code, if your system has been developed to retain the local fee and the NLA, you may load the data from the fields named “60% Local Fee Amt” and “60% Natl Limit Amt” to determine payment. For test codes for cervical or vaginal smears (pap smears), you should load the data from the field named “60% Pricing Amt” which reflects the lower of the local fee or the NLA, but not less than the national minimum payment amount. MACs should use the field “62% Pricing Amt” for payment to qualified laboratories of sole community hospitals.

Public comments and final payment determinations

On July 18, 2016, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input on payment methods for reconsidered 2016 codes and new 2017 codes. Notice of the meeting was published in the *Federal Register* May 13, 2016 and on the CMS website on approximately May 18, 2016. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*.

Additional written comments from the public were accepted until October 31, 2016. CMS has posted a summary of the public comments and the rationale for the final payment determinations at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2017-CLFS-Codes-Final-Determinations.pdf*.

Pricing information

The 2017 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for 2017, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2017 clinical laboratory fee schedule also includes codes that have a “QW” modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the clinical laboratory improvement amendments (CLIA).

Organ or disease-oriented panel codes

Similar to prior years, the 2017 pricing amounts for certain organ or disease-panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping information

New codes

G0659 is priced at the same rate as code G0479.

80305 is priced at the same rate as code G0477.

80306 is priced at the same rate as code G0478.

80307 is priced at the same rate as code G0479.

81327 is priced at the same rate as CPT® 81287.

81413 is priced at the same rate as CPT® 81435.

81414 is priced at the same rate as CPT® 81436.

81422 is priced at the same rate as CPT® 81436.

81439 is priced at the same rate as CPT® 81435.

81539 is priced at the same rate as CPT® 0010M

84410 is priced at the same rate as the sum of CPT® 84402 and 84403

87483 is priced at the same rate as CPT® 87633.

87338QW is priced at the same rate as CPT® 87338.

87631QW is priced at the same rate as CPT® 87631.

Existing codes:

81420 is priced at the same rate as CPT® 81435.

G0475 is priced at the same rate as CPT® 87389.

G0476 is priced at the same rate as CPT® 87624.

G0480 is priced at the same rate as 4.75 times CPT® 82542.

G0481 is priced at the same rate as 6.50 times CPT® 82542.

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G0482 is priced at the same rate as 8.25 times CPT® 82542.

G0483 is priced at the same rate as 10.25 times code 82542.

G0477, G0478, G0479, 0010M, and 82272QW are all to be deleted.

Laboratory costs subject to reasonable charge payment in 2017

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for 2017 is 1.0 percent.

Chapter 23, Sections 80 through 80.8 of the *Medicare Claims Processing Manual* contains instructions for determining the reasonable charge payment. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the HCPCS in the following list are performed for independent dialysis facility patients, Chapter 8, Section 60.3 of the *Medicare Claims Processing Manual* instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Note: Reasonable charge codes P9070, P9071, P9072 and 89337 may be included in the next calendar year's reasonable charge update.

Blood products

P9010	P9021	P9035	P9050	P9057
P9011	P9022	P9036	P9051	P9058
P9012	P9023	P9037	P9052	P9059
P9016	P9031	P9038	P9053	P9060
P9017	P9032	P9039	P9054	P9070
P9019	P9033	P9040	P9055	P9071
P9020	P9034	P9044	P9056	P9072

Also, payment for the following codes should be applied to the blood deductible as instructed in Chapter 3, Sections 20.5 through 20.5.4 of the *Medicare General Information, Eligibility and Entitlement Manual*.

P9010	P9022	P9040	P9056
P9016	P9038	P9051	P9057
P9021	P9039	P9054	P9058

Note: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine

86850	86891	86920	86932	86972
86860	86900	86921	86945	86975
86870	86901	86922	86950	86976
86880	86902	86923	86960	86977
86885	86904	86927	86965	86978
86886	86905	86930	86970	86985
86890	86906	86931	86971	

Reproductive medicine procedures

89250	89258	89272	89337	89353
89251	89259	89280	89342	89354
89253	89260	89281	89343	89356
89254	89261	89290	89344	
89255	89264	89291	89346	
89257	89268	89335	89352	

Additional information

The official instruction, CR 9909, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3687CP.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/*.

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Update to the federally qualified health centers prospective payment system – recurring file updates

***Note**: This article was revised January 5, 2017, to reflect the revised change request (CR) 9831 issued January 4. The CR revision corrected a typographical error in the fiscal year (FY) 2015 payment rate for grandfathered tribal FQHCs. In addition, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same. Previously published in the November 2016 Medicare A Connection, page 36.*

Provider types affected

This *MLN Matters*® article is intended for federally qualified health centers (FQHCs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 9831 updates the FQHC PPS base payment rate and the geographic adjustment factors (GAFs) for the FQHC pricer for 2017. Please ensure your billing staffs are aware of these changes.

Background

Payment for FQHCs under the prospective payment system

The Affordable Care Act (Section 10501(i)(3)(A); Pub. L. 111–148 and Pub. L. 111–152) added Section 1834(o) of the Social Security Act to establish a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates. In the PPS for FQHC final rule published in the May 2, 2014, *Federal Register* (79 FR 25436), the Centers for Medicare & Medicaid Services (CMS) implemented a methodology and payment rates for FQHCs under the PPS beginning on October 1, 2014.

Payment for grandfathered tribal federally qualified health centers (FQHCs) that were provider-based clinics on or before April 7, 2000

Effective for dates of service on or after January 1, 2016, indian health service (IHS) and tribal facilities and organizations that met the conditions of Section 413.65(m) on or before April 7, 2000, and have a change in its status on or after April 7, 2000, from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the conditions of participation (CoPs), may seek to become certified as grandfathered tribal FQHCs. These grandfathered tribal FQHCs would be required to meet all FQHC certification and payment requirements. The grandfathered PPS rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS.

FQHC PPS rate

Under the FQHC PPS, Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. The Social Security Act (Section 1834(o)(2)(B)(ii)) requires that the payment for the first year after the implementation year be increased by the percentage increase in the Medicare economic index (MEI). The Social Security Act (Section 1834(o)(2)(B)(ii)) also requires that in subsequent years, the FQHC PPS base payment rate will be increased by the percentage increase in a market basket of FQHC goods and services, or if such an index is not available, by the percentage increase in the MEI. In the 2017 physician fee schedule (PFS) final rule, CMS finalized a proposal to update the FQHC PPS base payment rate using a 2013-based FQHC market basket.

- Based on historical data through second quarter 2016, the final FQHC market basket for 2017 is 1.8 percent.
- From January 1, 2017, through December 31, 2017, the FQHC PPS base payment rate is $163.49.
- The 2017 base payment rate reflects a 1.8 percent increase above the 2016 base payment rate of $160.60.

In accordance with the Social Security Act (Section 1834(o)(1)(A)), the FQHC PPS base rate is adjusted for each FQHC by the FQHC GAF, based on the geographic practice cost indices (GPCIs) used to adjust payment under the PFS. The FQHC GAF is adapted from the work and practice expense GPCIs, and are updated when the work and practice expense GPCIs are updated for the PFS. For 2017, the FQHC GAFs have been updated in order to be consistent with the statutory requirements.

Grandfathered tribal FQHC PPS rate

Grandfathered tribal FQHCs are paid the lesser of their charges or a grandfathered tribal FQHC PPS rate for all FQHC services furnished to a beneficiary during a medically-necessary, face-to-face FQHC visit. From January 1, 2016, through December 31, 2016, the

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grandfathered tribal FQHC PPS rate is $324. FQHC claims (TOB 77x) for grandfathered tribal FQHCs submitted with dates of service on or after January 1, 2016, through December 31, 2016, paid at the 2015 rate of $307 must be adjusted and paid at the 2016 rate of $324. Grandfathered tribal FQHC claims with dates of service on or after January 1, 2017, through December 31, 2017, should be paid at the 2016 rate of $324 until CMS provides an updated payment rate for 2017. The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC PPS GAFs or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an IPPE or an AWV. The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the FQHC market basket adjustment that is applied annually to the FQHC PPS base rate, will not apply to the grandfathered tribal FQHC PPS rate.

Additional information

The official instruction, CR 9831, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3688CP.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

- January 5, 2017: Article revised to reflect a revised CR 9831. The CR was revised to correct a typographical error in the FY 2015 payment rate for grandfathered tribal FQHCs.
- November 15, 2016: Initial issuance

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Implementation Date: January 3, 2017

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.

Annual update of HCPCS codes used for home health consolidated billing enforcement

***Note**: This article was revised January 12, 2017, to correct table in the Background section. The table incorrectly listed code 97177. The correct code is 97167 (OT EVAL HIGH COMPLEX 60 MIN). All other information is unchanged. This information was previously published in the December 2016 Medicare A Connection, page 39.*

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs) and other providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

Provider action needed

Change request (CR) 9771 provides the 2017 annual update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS).

With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, K codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency.

The HCPCS codes in the table below are being added to the HH consolidated billing therapy code list, effective for services on or after January 1, 2017. These codes replace HCPCS codes: 97001, 97002, 97003, 97004.

HCPCS code	Descriptor
97161	PT EVAL LOW COMPLEX 20 MIN
97162	PT EVAL MOD COMPLEX 30 MIN
97163	PT EVAL HIGH COMPLEX 45 MIN
97164	PT RE-EVAL EST PLAN CARE
97165	OT EVAL LOW COMPLEX 30 MIN
97166	OT EVAL MOD COMPLEX 45 MIN
97167	OT EVAL HIGH COMPLEX 60 MIN
97168	OT RE-EVAL EST PLAN CARE

G0279 and G0280 are deleted from the HH consolidated billing therapy code list. These codes were replaced with 0019T and should have been removed from the list in earlier updates. Effective January 1, 2015, these codes were redefined for another purpose. MACs will adjust claims denied due to HH consolidated billing with HCPCS codes G0279 and G0280 and line item dates of service on or after January 1, 2015, if brought to their attention.

Additional information

The official instruction, CR 9771, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3618CP.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
1/12/17	This article was revised to correct in the table. The table incorrectly listed HCPCS code 97177. The correct HCPCS code is HCPCS 97167 (OT EVAL HIGH COMPLEX 60 MIN).
11/17/16	Initial article released

MLN Matters® Number: MM9771
Related Change Request (CR) #: CR 9771
Related CR Release Date: October 7, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3618CP
Implementation Date: January 3, 2017

Section 16001 and 16002 of the 21st Century Cures Act

Section 16005 of the 21st Century Cures Act

On December 13, 2016, the 21st Century Cures Act was enacted into law. Sections 16001 and 16002 amended Section 1833(t)(21) of the Social Security Act (as added by Section 603 of the Bipartisan Budget Act of 2015) and provided additional criteria about which off-campus departments of a provider will be "excepted" from payment under the Section 1833(t)(21)(C) of the Social Security Act.

The mid-build requirement specifies that, before November 2, 2015, the provider had a binding written agreement with an outside unrelated party for the actual construction of the department.

Section 16001:

Continuing Medicare payment under hospital outpatient department (HOPD) prospective payment system for services furnished by mid-build off-campus outpatient departments of providers.

For 2017:

- An off-campus department of a provider for which the Center for Medicare & Medicaid Services (CMS) received an attestation in accordance with the regulations at 42 CFR 413.65 (b)(3) prior to December 2, 2015, will be considered to be "excepted" from payment under Section 1833 (t)(21)(C). These off-campus departments of a provider should not use modifier "PN" on hospital outpatient claims for items and services furnished in 2017.

For 2018:

- An off-campus department of a provider will be excepted from payment under section 1833(t)(21)(C) of the Social Security Act for items and services furnished on or after January 1, 2018, and should not use modifier "PN" on hospital outpatient claims for items and services furnished on or after January 1, 2018, if it meets the requirements outlined below:
- A provider based attestation (pursuant to such section 413.65(b)(3)) is received no later than February 13, 2017, that such department met the requirements of a department of a provider specified in Section 413.65 of title 42 of the *Code of Federal Regulations*:
- The provider includes such department as part of the provider on its enrollment form in accordance with the enrollment process under Section 1866(j); and
- The department met the mid-build requirement (as defined at Section 1833 (t)(21)(B)(v)) and the Secretary receives a written certification that the department met such requirements and is signed by either the chief executive officer or chief operating officer of the main provider (as defined by 413.65 (b)(2)) (or equivalent if such titles are not used by the main provider) no later than February 13, 2017.
- Email submissions of the above requirements are acceptable.

Section 16002:

Treatment of cancer hospitals in off-campus outpatient department of a provider policy

- An off-campus outpatient department of a hospital paid under Section 1886(d)(1)(B)(v) of the Act (i.e., PPS-exempt Cancer Hospitals) is excepted from payment under Section 1833(t)(21)(C) if it met the provider-based requirements under 42 CFR 413.65 after November 1, 2015, and before December 13, 2016, and submitted an attestation with respect to such department in accordance with 42 CFR 413.65 (b)(3) no later than February 13, 2017. Such department should not use modifier "PN" on hospital outpatient claims for items and services furnished on or after January 1, 2017.
- Alternatively, in the case of an off-campus outpatient department of a hospital paid under Section 1886(d)(1)(B)(v) of the Act that meets the requirements of 42 CFR 413.65 after December 13, 2016, such applicable items and services furnished by such department will be excepted from payment under Section 1833(t)(21)(C) if the Secretary receives from a provider a provider-based attestation that states such requirements were met no later than 60 days after the date such requirements were first met by such department. Such department should not use modifier "PN" on hospital outpatient claims.

Medicare Learning Network®

The *Medicare Learning Network®* (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

Upcoming provider outreach and educational events

Getting to know Cotiviti (Part A/B)

Date: Thursday, February 23
Time: 10:00 a.m.-11:00 a.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0366061.asp

First Coast and CGS Administrators collaborative webcast: Nebulizers and inhalation medication

Date: Wednesday, March 8
Time: 12:30-2:00 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0366842.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® for January 5, 2017

Editor's Note

Best wishes for a happy and healthy 2017. Your MLN Connects® Provider eNews has a new name and design for the New Year. *Let us know* what you think. MLN Connects® still delivers the weekly Medicare news you expect but with a fresh new style from the *Medicare Learning Network® (MLN)*.

MLN Connects® for January 5, 2017

View this edition as a PDF

News & Announcements

- Apply for Clinical Practice Improvement Activities and Measurement Study by January 31
- Updated ESRD PPS Website
- Comparative Billing Report on Physical Therapy in February
- EHR Incentive Programs: New Attestation Resources
- Implementation Guide for QRDA-III Eligible Clinician Programs Available
- January Quarterly Provider Update Available
- Get Your Patients Off to a Healthy Start in 2017

Provider Compliance

- Duplicate Claims Will Not be Paid

Claims, Pricers & Codes

- Fee Schedule Amounts for Group 3 Power Wheelchair Accessories and Cushions

Upcoming Events

- ESRD QIP: Payment Year 2020 Final Rule Call — January 17
- Home Health Groupings Model Technical Report Call — January 18
- Hospice Quality Reporting Program Provider Training — January 18
- Home Health Quality of Patient Care Star Rating Call — January 19
- Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

Medicare Learning Network® Publications & Multimedia

- Quality Payment Program Video Presentation — New
- Hospital Settlement Call: Audio Recording and Transcript — New
- Medicare Overpayments Fact Sheet — Revised
- PECOS for Provider and Supplier Organizations Fact Sheet — Revised
- Long-Term Care Hospital Prospective Payment System Booklet — Reminder
- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet — Reminder

MLN Connects® for January 12, 2017

MLN Connects® for January 12, 2017
View this edition as a PDF

News & Announcements

- Addressing the Opioid Epidemic: Keeping Medicare and Medicaid Beneficiaries Healthy
- Post-Acute Care TOH Quality Measures Pilot Study: Respond by January 17
- Clinical Laboratories: Prepare Now to Report Lab Data through March 31
- Chronic Care Management Services Changes for 2017
- eCQI Resource Center Integrated with USHIK
- eCQM Value Sets for 2017 Performance Period: Addendum Available
- Medicare Quality Programs: ICD-10 Code Updates and Impact to 4th Quarter 2016
- January is Cervical Health Awareness Month

Provider Compliance

- CMS Provider Minute: CT Scans Video

Upcoming Events

- ESRD QIP: Payment Year 2020 Final Rule Call — January 17
- Home Health Groupings Model Technical Report Call — January 18
- Home Health Quality of Patient Care Star Rating Call — January 19
- Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

Medicare Learning Network® Publications & Multimedia

- Additional Guidance for Clinical Laboratories as Data Reporting Begins *MLN Matters®* Article — New

- Revised CMS 855S Application: DMEPOS Suppliers *MLN Matters®* Article — New
- Chronic Care Management Services Changes for 2017 Fact Sheet — New
- How to Use the Medicare Coverage Database Booklet — Revised
- SNF Prospective Payment System Booklet — Revised
- Acute Care Hospital Inpatient Prospective Payment System Booklet — Revised
- HH Prospective Payment System Booklet — Revised
- IRF Prospective Payment System Fact Sheet — Revised
- Chronic Care Management Services Fact Sheet — Revised
- Medicare Vision Services Fact Sheet — Revised
- Swing Bed Services Fact Sheet — Revised
- Mass Immunizers and Roster Billing Fact Sheet — Revised

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® for January 19, 2017

MLN Connects® for January 19, 2017

View this edition as a PDF

News & Announcements

- Over 40 Million Medicare Beneficiaries Utilized Free Preventive Services in 2016
- Prosthetics and Custom Fabricated Orthotics Practitioners and Suppliers: Establishment of Special Payment Provisions and Requirements
- eCQM Data: Extension of 2016 Reporting Deadline to March 13
- EHR Incentive Program: Attest to 2016 Program Requirements by February 28
- EHR Incentive Programs: Calculations for Objectives and Measures Requiring Patient Action
- CMS Releases ESRD QIP Performance Score Reports for PY 2017
- New Care Management Webpage
- Provider Enrollment Application Fee Amount for CY 2017
- 2017 Annual Stationary Oxygen Budget Neutrality Calculations
- Glaucoma Awareness Month: Make a Resolution for Healthy Vision

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities

Claims, Pricers & Codes

- OPPS Hospital Claim Issues

Upcoming Events

- Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

Medicare Learning Network® Publications & Multimedia

- Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 2] — New
- Medicare Parts C and D General Compliance Web-Based Training Course — Revised
- Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training Course — Revised
- Health Care Professional Frequently Used Web Pages Educational Tool — Revised
- ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT®, and HCPCS Code Sets Educational Tool — Reminder

SPOT

From front page

- Cardiovascular disease screening
- Colorectal cancer screening
- Diabetes screening tests
- Fecal occult blood test
- Glaucoma screening
- High intensity behavioral counseling
- Initial preventive physical examination
- Intensive behavioral therapy for cardiovascular disease
- Intensive behavioral therapy for obesity
- Mammography screening
- Pap test screening
- Pelvic screening exam
- Prostate cancer screening
- Smoking cessation

Using SPOT to access *preventive services information* for your patient may significantly reduce your number of claim denials by checking the preventive services information before performing a test and providing the service.

"Once we had access to SPOT, I went in and pulled the first two months of claims data through the provider data summary (PDS) report," said *Tracie Jones, a Medicare billing manager for Simon-Med facilities in Central Florida*.

"Most, if not all, of the denial codes we had were related to routine ultrasound tests and preventative exams. One procedure with an extraordinary high number of denials was DXA, a bone density test for measuring bone mineral density that is only covered by Medicare once every two years, Jones explained. "We worked with our scheduling department to make sure we were only performing the DXA test according to Medicare guidelines."

With SPOT, Medicare providers have several tools available to diagnose, correct, and prevent denied claims. SPOT gives you 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). First Coast offers SPOT to providers at no charge.

How to get your SPOT account

First Coast *provides a step-by-step guide* to assist you in establishing your SPOT 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)

Beneficiary customer service

1-800-MEDICARE (1-800-633-4227)

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