Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

March 2017

In this issue

Updates to the 'Medicare Claims Processing Manual' to correct remittance advice messages

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

This article is based on change request (CR) 9906, which revises Chapters 12, 17, and 23 of the *Medicare Claims Processing Manual* (the manual) to ensure that all remittance advice coding is consistent with national standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual. MACs will ensure that they apply remittance advice coding as described in the revised manual sections. Make sure that your billing staffs are aware of these changes.

Background

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, Claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) may be used. The rule requires specific codes, which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. CR 9906 updates Chapters 12, 17, and 23 of the manual to reflect the standard format and to correct any non-compliant code combinations.

Additional information

The official instruction, CR 9906, issued to your MAC regarding this change, is available at *https://www.*

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Contents

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

Publication staff:
Terri Drury
Maria Murdoch
Mark Willett
Robert Petty

Fax comments about this publication to:

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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.

Instructions to process services not authorized by the Veterans Administration (VA) in a non-VA facility reported with value code (VC) 42

Note: This article was revised February 17, 2017, to reflect a revised change request (CR) 9818 issued on February 14. In the article, the CR release date, transmittal number, and the web address for accessing the CR were revised. All other information remains the same. It was previously published in the November 2016 edition page 7.

Provider types affected

This *MLN Matters*® article is intended for hospitals and skilled nursing facilities who submit inpatient claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9818 corrects a misinterpretation of the changes made with CR8198 - Updating the shared systems and common working file (CWF) to no Longer Create Veteran Affairs (VA) "I" records in the Medicare secondary payer (MSP) auxiliary file. CR 9818 clarifies how Medicare contractors will process inpatient claims for services in a non-VA facility that were not authorized by the VA. Make sure that your billing staff are aware of these changes.

Background

The Social Security Act (Section 1862(a) (3) precludes Medicare from making payment for services or items that are paid for directly or indirectly by another government entity.

The Centers for Medicare & Medicaid Services (CMS) issued *MLN Matters*® *Special Edition* article (SE) 1517 to provide clarification and coding reminders for billing Medicare when the Department of Veterans Affairs (VA) is involved for a portion of the services.

CMS was recently notified of a scenario where a hospital cannot follow the instructions in SE 1517 to split the claim to bill Medicare for only the non-VA authorized services as instructed in SE 1517.

Currently hospitals submit no pay inpatient claims paid by the VA to Medicare for the purpose of crediting the Part A deductible and coinsurance amounts. This process is not changing.

Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. For inpatient claims where the VA is the payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn't approve all the services, any Medicare covered services not considered by the VA may be billed to the Medicare program.

When a VA- eligible beneficiary chooses to receive services in a Medicare certified facility for which the VA has not authorized, the facility shall use condition code 26 to indicate the patient is a VA eligible patient and chooses to receive services in a Medicare Certified provider instead of a VA facility and value code 42 with the amount of the VA payment for the authorized days.

MACs will accept value code '42' on inpatient claims with type of bill codes 11x, 18x, 21x, 41x and 51x. MACs will calculate the Medicare payment for an inpatient claim when condition code '26' and value code '42' are present on a claim. However, MACs will return the claim to the provider if CC '26' is present without VC '42' or vice versa.

Additional information

The official instruction, CR 9818, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3718CP.pdf*.

Special Edition Article (SE) 1517 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1517.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

• October 31, 2016 - Initial issuance
• February 17, 2017 - Article updated to reflect a revised CR 9818 issued February 14, 2017. In the article, the CR release date, transmittal number, and the web address for accessing the CR were revised. All other information remains the same.

MLN Matters® Number: MM9818 *Revised*
Related Change Request (CR) #: CR 9818
Related CR Release Date: February 14, 2017
Effective Date: October 1, 2013
Related CR Transmittal #: R3718CP
Implementation Date: April 3, 2017

Gender dysphoria and gender reassignment surgery

Provider types affected

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

What you need to know

This article is based on change request (CR) 9981, which informs MACs that coverage determinations for gender reassignment surgery will continue to be made by the local MACs on a case-by-case basis. Make sure that your billing staffs are aware of these changes.

Background

On August 30, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final decision memorandum (DM) on gender reassignment surgery for gender dysphoria. Importantly, the DM did not create or change existing policy – CMS did not issue a national coverage determination (NCD).

The purpose of this CR is to include an explanatory paragraph about gender reassignment surgery in the *Medicare NCD Manual* at Chapter 1, Part 2, Section 140.9. This is in response to public inquires to have information about gender reassignment surgery among Medicare coverage information.

Policy: Effective for claims with dates of service on or after August 30, 2016, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act and any other relevant statutory requirements, will continue to be made by the local Medicare administrative contractors (MACs) on a case-by-case basis.

Additional information

The official instruction, CR 9981, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R194NCD.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	Description
March 6, 2017	Article released

MLN Matters® Number: MM9981
Related Change Request (CR) #: CR 9981
Related CR Release Date: March 3, 2017
Effective Date: August 30, 2016
Related CR Transmittal #: R194NCD
Implementation Date: April 4, 2017

Provider Enrollment Revalidation – Cycle 2

***Note:** This article was revised on March 15, 2017, to update the table on page 6 and added additional information after that table. All other information is unchanged. This article was published previously in the March 2016 edition pages 34-37.*

Provider types affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), Medicare Carriers, Fiscal Intermediaries, and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements that are captured within this article.

Caution – What you need to do

1. Check *http://go.cms.gov/MedicareRevalidation* for the provider/suppliers due for revalidation;
2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:
    - Submit a revalidation application through Internet-based PECOS located at *https://pecos.cms.hhs.gov/pecos/login.do*, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper

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certification statement and mail it along with your supporting documentation to your MAC; or

- Complete the appropriate CMS-855 application available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html*;
- If applicable, pay your fee by going to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*; and
- Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria.
CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

What's ahead for your next Medicare enrollment revalidation?

Established Due Dates for Revalidation

CMS has established due dates by which the provider/supplier's revalidation application must reach the MAC in order for them to remain in compliance with Medicare's provider enrollment requirements. The due dates will generally be on the **last day of a month** (for example, June 30, July 31 or August 31). Submit your revalidation application to your MAC within 6 months of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

- The list will be available at **http://go.cms.gov/MedicareRevalidation** and will include **all** enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a "TBD" (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at **http://go.cms.gov/MedicareRevalidation** on the CMS website.

  IMPORTANT: The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.

- Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).
- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier's due date.

  Revalidation notices sent via email will indicate **"URGENT: Medicare Provider Enrollment Revalidation Request"** in the subject line to differentiate from other emails. If all of the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

  NOTE: Providers/suppliers who are within 2 months of their listed due dates on http://go.cms.gov/MedicareRevalidation but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.

- To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

Large Group Coordination

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming 6 month period. A spreadsheet detailing the applicable provider's Name, National Provider Identifier (NPI) and Specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.
Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on *http://go.cms.gov/*

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MedicareRevalidation to determine their provider/supplier's revalidation due dates.

Unsolicited Revalidation Submissions

All unsolicited revalidation applications submitted more than 6 months in advance of the provider/supplier's due date will be ***returned***.

- What is an unsolicited revalidation?
  - If you are not due for revalidation in the current 6 month period, your due date will be listed as "TBD" (To Be Determined). This means that you do not yet have a due date for revalidation. **Please do not submit a revalidation application if there is NOT a listed due date.**
  - Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
- If your intention is to submit a change to your provider enrollment record, you must submit a *'change of information'* application using the appropriate CMS-855 form.

Submitting Your Revalidation Application

IMPORTANT: Each provider/supplier is required to revalidate their entire Medicare enrollment record.

A provider/supplier's enrollment record includes information such as the provider's individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided). This means the provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and Provider Transaction Access Numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to *https://pecos.cms.hhs.gov/pecos/login.do*. PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html* on the CMS website.

Getting Access to PECOS:
To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as "I&A". The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.

To learn more about establishing an I&A account or to verify your ability to submit applications using PECOS, please refer to *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*.

If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the revalidation notice. You may also find a list of MAC's at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1-866-484-8049 or at *EUSSupport@cgi.com*.

Deactivations Due to Non-Response to Revalidation or Development Requests

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

NOTE: The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will **not** be granted. Services

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provided to Medicare patients during the period between deactivation and reactivation are the provider's liability.

Revalidation Timeline and Example

Providers/suppliers may use the following table /chart as a guide for the sequence of events through the revalidation progression.

Action	Timeframe	Example
Revalidation list posted	Approximately 6 months prior to due date	March 30, 2017
Issue large group notifications	Approximately 6 months prior to due date	March 30, 2017
MAC sends email/letter notification	75 – 90 days prior to due date	July 2 - 17, 2017
MAC sends letter for undeliverable emails	75 – 90 days prior to due date	July 2 - 17, 2017
Revalidation due date		**September 30, 2017**
Apply payment hold/issue reminder letter (group members)	Within 25 days after due date	October 25, 2017
Deactivate	60 – 75 days after due date	7

Deactivations Due to Non-Billing

Providers/suppliers that have not billed Medicare for the previous 12 consecutive months will have their Medicare billing privileges deactivated in accordance with 42 CFR §424.540. The effective date of deactivation will be 5 days from the date of the corresponding deactivation letter issued by the MACs notifying the providers/suppliers of the *deactivation* action.

Providers/suppliers who Medicare billing privileges are deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

Application Fees

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $560.00 for Calendar Year (CY) 2017. CMS has defined "institutional provider" to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2017 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do* and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with your uploaded documents on PECOS or mail it to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

SUMMARY:

- CMS will post the revalidation due dates for the upcoming revalidation cycle on *http://go.cms.gov/MedicareRevalidation* for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier's billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
- If the provider/supplier has not billed Medicare for the previous 12 consecutive months, the MAC will deactivate their Medicare billing privileges.
- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will

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result in a gap in coverage.

- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional information

To find out whether a provider/supplier has been mailed a revalidation notice go to *http://go.cms.gov/MedicareRevalidation* on the CMS website.

A sample revalidation letter is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certi ication/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf on the CMS website.* A revalidation checklist is available at *http://www.cms. gov/Medicare/Provider-Enrollment-and-Certi ication/MedicareProviderSupEnroll/Revalidations.html* on the CMS website.

For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf* on the CMS website.

For more information about the application fee payment process, refer to MLN Matters Article SE1130, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf* on the CMS website.

The MLN fact sheet titled "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf* on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to *https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin* to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment webpage at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*.

If you have questions, contact your MAC. Medicare provider enrollment contact information for each State can be found at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf*.

Document history

Date of Change	Description
March 15, 2017	The updated article revised the table on page 6 and added additional information after that table.
February 22, 2016	Initial article released

MLN Matters® Number: SE1605 *Revised*
Related Change Request (CR) #: CR N/A
Related CR Release Date: N/A
Effective Date: N/A
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Implementation Date: N/A

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cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3721CP.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: MM9906
Related Change Request (CR) #: CR 9906
Related CR Release Date: February 24, 2017
Effective Date: May 25, 2017
Related CR Transmittal #: R3721CP
Implementation Date: May 25, 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*.

Clarifications to LCDs

Rezum® System for use in the management of benign prostatic hypertrophy -- clarification regarding the system

On August 27, 2015, the FDA cleared for marketing the Rezum® System to relieve lower urinary tract symptoms secondary to benign prostatic hyperplasia. This procedure involves the transurethral injection of steam into the prostate. Once injected, the steam condenses to water, imparting convective energy to the tissue, causing cell death and damage. The technology uses radiofrequency (RF) to boil the water to create the steam that is injected, but does not impart radiofrequency directly to the prostate tissue.

Claims for procedures involving Rezum® should be coded as Current Procedural Terminology® (CPT®) code 53899 (Unlisted procedure, urinary system). The claim must also indicate that the Rezum® procedure was performed in Box 19 on the CMS 1500 form (or its electronic equivalent).

Claims for procedures involving Rezum® transurethral steam injection should not be coded as CPT® 53852 (Transurethral destruction of prostate tissue; by radiofrequency thermotherapy). CPT® code 53852 is intended for transurethral prostatic tissue destruction technology that imparts radiofrequency directly to the prostate tissue.

Revisions to LCDs

Gene expression profiling panel for use in the management of breast cancer treatment -- revisions to the Part A/B LCD

LCD ID number: L33586 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for gene expression profiling panel for use in the management of breast cancer treatment was revised based on a reconsideration request to add Current Procedural Terminology® (CPT®) code 81479 [Unlisted molecular pathology procedure] for MammaPrint® with limited indications. The "Indications and Limitations of Coverage and/or Medical Necessity," "CPT®/HCPCS Codes", "ICD-10 Codes that Support Medical Necessity", and "Sources of Information and Basis for Decision" sections of LCD were updated.

Effective date

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

Controlled substance monitoring and drugs of abuse testing -- revision to the Part A and Part B LCD

LCD ID number: L36393 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on the 2017 HCPCS Update (CR9752), HCPCS codes G0477-G0479 were deleted and replaced with CPT® codes 80305-80307 in the "CPT®/HCPCS Codes" section of the local coverage determination (LCD) for controlled substance monitoring and drugs of abuse testing.

Effective date

This LCD revision is effective for claims processed **on or after March 9, 2017**, for services rendered **on or after January 1, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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*.

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

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

The following services were evaluated and determined that they are not considered medically reasonable and necessary at this time based on current available published evidence (e.g., peer-reviewed medical literature, and published studies). Therefore, the following procedure codes have been added to the noncovered services local coverage determination (LCD).

- 0437T Implantation of non-biologic or synthetic implant (e.g., polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)
- 0438T Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance
- 0439T Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)
- 0440T Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve
- 0441T Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve
- 0442T Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial plexus, pudendal nerve)
- 0443T Real time spectral analysis of prostate tissue by fluorescence spectroscopy, including imaging guidance (List separately in addition to code for primary procedure)
- 0444T Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral
- 0445T Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral
- L8699+ Prosthetic implant, not otherwise specified (when used for hydrogel application of a spacer to increase the distance between the prostate and anterior rectal wall)

Additionally, CPT® code 84999+ [Cancer Type ID], was removed from the unlisted procedure codes Part A and Part B.

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the quality of the evidence per the Program Integrity Manual.

When addressing the articles and related information in the public domain, the jurisdiction N (JN) Medicare administrative contractor (MAC) reached the determination that available evidence was of moderate to low quality, consisting of small case series, retrospective studies, and review articles reporting limited safety and efficacy data for these procedures. Due to the unavailability of high quality evidence, the JN MAC concluded that there is insufficient scientific evidence to support these procedures, and therefore they are not considered reasonable and necessary under Section 1862(a)(1)(a) of the Social Security Act.

Any denied claim would have Medicare appeal rights. The second level of appeal (qualified independent contractor) requires review by a clinician to uphold any denial. Providers should submit for review all the relevant medical documentation and case specific information of merit and/ or new information in the public domain.

An interested stakeholder can request a reconsideration of an LCD after the draft is finalized, the notice period has ended, and the draft becomes active. In the case of the noncovered services LCD, the stakeholder may request the list of the articles and related information in the public domain that were considered by the medical policy department in making the noncoverage decision. If the stakeholder has new information based on the evaluation of the list of articles and related information, an LCD reconsideration request can be initiated. It is the responsibility of the interested stakeholder to request the evidentiary list from the contractor and to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the website.

Effective date

The LCD revision for the addition of CPT codes 0437T, 0438T/L8699, 0439T, 0440T - 0442T, 0443T and 0444T - 0445T and is effective for services rendered **on or after May 1, 2017.**

The LCD revision for the removal of CPT code 84999+ [Cancer Type ID], is effective for claims processed **on or after March 27, 2017,** for dates of service **on or after January 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, please *click here*.

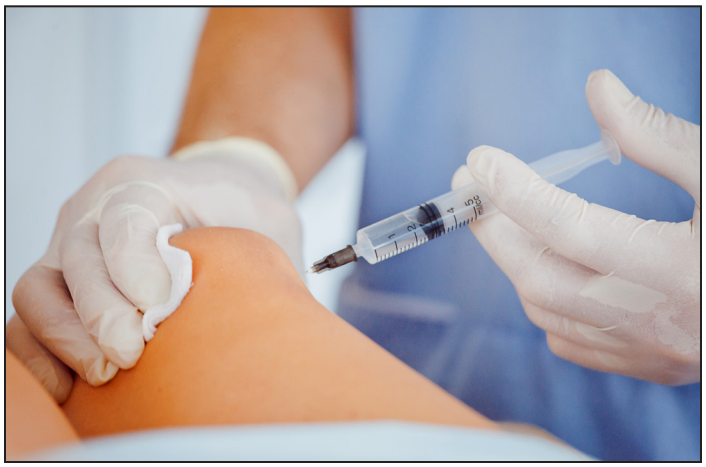
Viscosupplementation therapy for knee -- revision to the Part A and Part B LCD

LCD ID number: L33767 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee was revised based on a reconsideration request to correct the dosage and duration of treatment for GenVisc 850®, per the Food and Drug Administration (FDA) guidelines. The "Weekly Dosage/Injections per week" column was revised to read "25 mg/1", the "Total Dosage" column was revised to read "75 to 125 mg", and the "Duration of Treatment" column was revised to read 3 to 5 weeks/single course of treatment per knee" in the "Utilization Guidelines" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 1, 2017**, for services rendered **on or after January 1, 2016**. 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*.

Paclitaxel (Taxol®) -- revision to the Part A and Part B LCD

LCD ID number: L33730 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for paclitaxel (Taxol®) was revised based on a reconsideration request to add malignant neoplasm of vulva to the list of off-label indications within the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, ICD-10-CM diagnosis codes C51.8 and C51.9 were added 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 March 9, 2017**. 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*.

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Advance care planning implementation for outpatient prospective payment system claims

Provider types affected

This *MLN Matters*® article is intended for physicians and providers submitting claims on type of bill 13x to Medicare administrative contractors (MACs) for advance care planning (ACP) services payable under the outpatient prospective payment system (OPPS).

Provider action needed

This article is based on change request (CR) 9862 which implements system changes necessary to process ACP services for OPPS claims. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) made Current Procedural Terminology® (CPT®) code 99497 for ACP separately payable for OPPS claims when the service meets the criteria for separate payment under the OPPS. This policy changes will be implemented through the annual Medicare physician fee schedule database (MPFSDB) update.

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

CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)) is an add-on code and therefore payment for the service described by this code is unconditionally packaged (assigned status indicator "N") in the OPPS in accordance with 42 CFR 419.2(b)(18).

CMS is including voluntary ACP as an optional element of the annual wellness visit (AWV). ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service. Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV and billed with a covered AWV code. However, if the AWV payment is denied, MACs will apply the deductible and coinsurance. Remember that the deductible and coinsurance for ACP billed with an AWV can only be waived once a year. When ACP services are furnished on the same day and by the same provider as a covered AWV, they are reimbursed under the MPFSDB rates.

Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.

Voluntary ACP, upon agreement with the patient, is an optional element of the AWV. When ACP services are provided as a part of an AWV, practitioners would report CPT code 99497 (plus add-on code 99498 for each additional 30 minutes, if applicable) for the ACP services in addition to either of the HCPCS AWV codes G0438 (Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit) and G0439 (Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit). When voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible do not apply for ACP. The deductible and coinsurance does apply when ACP is not furnished as part of a covered AWV.

MACs will adjust claims ACP claims processed incorrectly from January 1, 2016 forward when ACP was an optional element of the annual wellness visit (AWV).

Additional information

The official instruction, CR 9862, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1795OTN.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: MM9862
Related Change Request (CR) #: CR 9862
Related CR Release Date: February 10, 2017
Effective Date: January 1, 2016
Related CR Transmittal #: R1795OTN
Implementation Date: July 3, 2017

Clarification of admission order and medical review requirements

Provider types affected

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

Provider action needed

Change request (CR) 9979, from which this article was developed, clarifies the rulemaking language of the Centers for Medicare & Medicaid Services (CMS) as it relates to "Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A; Requirements for Physician Orders." The updated language will be added to *Chapter 1, Section 10.2* (Hospital Inpatient Admission Order and Certification) of the *Medicare Benefit Policy Manual* (Pub. 100-02).

Background

In response to concerns about the provision of observation services for increasingly long periods of time and in response to stakeholders' concerns about the clarity and appropriateness of Medicare's hospital inpatient admission and medical review guidelines, CMS published several clarifications and changes in policy in the fiscal year (FY) 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital (LTCH), PPS final rule and subsequent rulemaking. These clarifications and changes remain in the text of the final rules. However, the *Benefit Policy Manual* has not been updated to reflect the same clarifications and changes. CR 9979 resolves that issue.

In the FY 2014 IPPS/LTCH PPS final rule and subsequent rulemaking, CMS clarified and specified that an individual becomes an inpatient of a hospital, including a critical access hospital (CAH), when formally admitted as such pursuant to an order for inpatient admission by a physician or other qualified practitioner described in the final regulations. The order is required for payment of hospital inpatient services under Medicare Part A.

CMS specified that for those hospital stays in which the physician expects the beneficiary to require care that crosses two midnights and admits the beneficiary based upon that expectation, Medicare Part A payment is generally appropriate. Conversely, CMS specified that hospital stays in which the physician expects the patient to require care less than two midnights, payment under Medicare Part A is generally inappropriate.

This revised CMS guidance to hospitals and physicians relating to when hospital inpatient admissions are determined reasonable and necessary for payment under Part A.

Additional information

The official instruction, CR 9979, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R234BP.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	Description
March 10, 2017	Initial article released

MLN Matters® Number: MM9979
Related Change Request (CR) #: CR 9979
Related CR Release Date: March 10, 2017
Effective Date: January 1, 2016
Related CR Transmittal #: R234BP
Implementation Date: June 12, 2017

Clarification of Patient Discharge Status Codes and Hospital

Note: *This article was rescinded on March 15, 2017. Information on the inpatient transfer policy is located in the "Medicare Claims Processing Manual" (100-04), Chapter 3. For questions concerning clarification on the proper usage of patient discharge status codes, providers should be utilizing the "UB-04 Manual" which is maintained by the National Uniform Billing Committee.*

MLN Matters® Number: SE0801 *Rescinded*
Related Change Request (CR) #: CR 9862
Related CR Release Date: February 10, 2017
Effective Date: January 1, 2016
Related CR Transmittal #: R1795OTN
Implementation Date: July 3, 2017

Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) - Recurring File Updates

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

Change Request (CR) 10021 instructs MACs to adjust all FQHC claims (77X) for GFT FQHCs submitted with dates of service on or after January 1, 2017, through June 30, 2017, paid at the previous rate. These adjustments will be completed 45 days after the implementation of CR 10021. Make sure your billing staff is aware of these changes.

Background

Effective for dates of service on or after January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations may seek to become certified as a Grandfathered Tribal (GFT) Federally Qualified Health Center (FQHC) if the facility or organization:

- Met the conditions of 42CFR §413.65(m) (*Requirements for a Determination That a Facility or an Organization Has Provider-Based Status*) on or before April 7, 2000, and
- Had a change in their 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, and
- No longer meets the Medicare Conditions of Participation (CoPs).

These GFT FQHCs would be required to meet all FQHC certification and payment requirements. The grandfathered Prospective Payment System (PPS) rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS. GFT FQHCs are paid the lesser of their charges (or a GFT FQHC PPS rate) for all FQHC services furnished to a beneficiary during a medically-necessary face-to-face FQHC visit.

Note: From January 1, 2017, through December 31, 2017, the GFT FQHC PPS rate is $349.

FQHC claims (TOB 77X) for GFT FQHCs that are submitted with dates of service on or after January 1, 2017, through June 30, 2017, and paid at the Calendar Year (CY) 2016 rate of $324 must be adjusted and paid at the CY 2017 rate of $349.

GFT FQHC claims that are submitted with dates of service on or after January 1, 2018, through December 31, 2018, should be paid at the CY 2017 rate of $349 until the Centers for Medicare & Medicaid Services (CMS) provides an updated payment rate for CY 2018.

The GFT FQHC PPS rate will not be adjusted by the FQHC PPS Geographic Adjustment Factors (GAFs) or be eligible for the special payment adjustments under the

FQHC PPS for new patients, or patients receiving an Initial Preventive Physical Exam (IPPE) or an Annual Wellness Visit (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 GFT FQHC PPS rate.

MACs will adjust FQHC claims (77X) for GTF FQHCs submitted with dates of service on or after January 1, 2017, through June 30, 2017, paid at the previous rate. These adjustments will be completed 45 days after the implementation of CR10021.

Additional information

The official instruction, CR 10021, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3734CP.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: MM10021
Related Change Request (CR) #: CR 10021
Related CR Release Date: March 10, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3734CP
Implementation Date: July 3, 2017

April 2017 integrated outpatient code editor (I/OCE) specifications version 18.1

Provider types affected

This *MLN Matters*® article is intended for providers who submit institutional claims to Medicare administrative contractors (MACs), including home health and hospice (HH+H) MACs for services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 10002 provides instructions and specifications for the integrated outpatient code editor (I/OCE) used for outpatient prospective payment system (OPPS) and non-OPPS claims.

This is for hospital outpatient departments, community mental health centers, all non-OPPS providers and for limited services when provided in a home health agency not under the home health prospective payment system (PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staff is aware of these changes.

The I/OCE specifications will be posted at *http://www.cms.gov/OutpatientCodeEdit/*. These specifications contain the appendices mentioned in the table below.

Key I/OCE changes for April 2017

The following table summarizes the modifications of the I/OCE for the April 2017 v18.1 release. Note that some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the "Effective Date" column.

Effective date	Edits affected	Modification
1/1/2017	101	Update Section 603 logic to remove observation and change Payment Method Flag assignment to 8 (see Appendix E, Appendix Q of attachment to CR10002).
1/1/2017		Update Section 603 logic to change the Payment Method Flag to 8 for New Technology Ambulatory Payment Classifications (APC) (see Appendix Q).
1/1/2015		Update comprehensive APC logic to clear Composite Adjustment Flag assignment (if present) from the output when reported on a comprehensive APC claim (see Special processing logic, Appendix K - multiple imaging composite and Appendix L).

Effective date	Edits affected	Modification
1/1/2017		Update logic to output Status Indicator (SI) = E1 for revenue codes reported without HCPCS codes that previously had SI = E (see Appendix N).
1/1/2017		Update logic for Advance Care Planning (ACP) to revert to processing at the day level (not claim level). Additionally, update logic for add-on ACP code 99498 to retain SI = N when reported on a claim with the Annual Wellness Visit (AWV) but without primary ACP code 99497 (see Special processing logic).
2/1/2017	68	Implement mid-quarter coverage for new Proprietary Laboratory Analysis (PLA) codes 0001U, 0002U, and 0003U.
4/1/2017	84	Terminate the editing requirements for Partial Hospitalization Program (PHP)/ Community Mental Health Centers (CMHC) add-on codes reported without a primary PHP procedure (see notes in Table 4 and Appendix F-a).
1/1/2017		Correct conditional APC program logic to assign standard SI/APC for critical care ancillary service codes 36600, 43752 and 94660 that have SI = Q1 when the codes are reported without critical care or other payable HCPCS.
4/1/2017		Revised documentation in the special processing logic section for Conditional APC processing and Critical Care Ancillary Services processing for clarity; this clarification does not represent any changes to the processing logic.

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Effective date	Edits affected	Modification
4/1/2017		Update the following lists for the release (see quarterly data files): - Edit 99 exclusion list - Device procedure list (edit 92) - Skin substitute product list (edit 87 and Appendix O) - Complexity-adjusted comprehensive APC pairs (new table, CapcPairs) - Terminated Device-Procedures (terminated procedures or those submitted for device credit): note several codes with corrected device credit amounts - Code Pairs (termination of PHP pairs for edit 84; move complexity-adjusted pairs to new table CapcPair) - Offset APC (Contrast APCs subject to pass-through offset) - Radiation HCPCS (new table listing HCPCS subject to Section 603 exclusion logic)
4/1/2017		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
4/1/2017	20, 40	Implement version 23.1 of the NCCI (as modified for applicable outpatient institutional providers)

Additional information

The official instruction, CR 10002, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3735CP.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	Description
March 10, 2017	Initial article released

MLN Matters® Number: MM10002
Related Change Request (CR) #: CR 10002
Related CR Release Date: March 10, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3735CP
Implementation Date: April 3, 2017

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April 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 (MAC), including home health and hospice (HH&H) MACs, for services provided to Medicare beneficiaries paid under the outpatient prospective payment system (OPPS).

Provider action needed

Change request (CR) 10005 describes changes to and billing instructions for various payment policies implemented in the April 2017 OPPS update. The April 2017 integrated outpatient code editor (I/OCE) 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 10005. Make sure your billing staff is aware of these changes.

Background

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

Proprietary laboratory analyses (PLA) CPT® codes effective February 1, 2017

The American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel established three new PLA CPT codes, specifically CPT codes 0001U, 0002U and 0003U. The long descriptors for the codes are listed in Table 1. Because the codes were effective February 1, 2017, they were not included in the January 2017 I/OCE update and the January 2017 OPPS Addendum B.

Table 1 - PLA CPT Codes Effective February 1, 2017

CPT® code	Long descriptor	OPPS SI
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported	A
0002U	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps	Q4

CPT® code	Long descriptor	OPPS SI
0003U	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score	Q4

Under the hospital OPPS, CPT® code 0001U is assigned to status indicator "A" and CPT codes 0002U and 0003U are assigned to status indicator "Q4" (conditionally packaged laboratory tests) effective February 1, 2017. For more information on OPPS SI "A" and "Q4," refer to OPPS Addendum D1 of the 2017 OPPS/ASC final rule for the latest definitions to the OPPS status indicators for 2017.

CPT® codes 0001U, 0002U and 0003U have been added to the April 2017 I/OCE with an effective date of February 1, 2017. These codes, along with their short descriptors and status indicators, are also listed in the April 2017 OPPS Addendum B at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Coding Changes for Presumptive Drug Tests Effective January 1, 2017

Prior to 2017, HCPCS codes G0477, G0478 and G0479 were used to describe presumptive drug tests. For the 2017 update, the AMA CPT Editorial Panel established three new CPT® codes, specifically CPT codes 80305, 80306, and 80307, to describe the same presumptive drug tests as the HCPCS G-codes. Consequently, the HCPCS G-codes were terminated on December 31, 2016. Because CPT® codes 80305, 80306 and 80307 describe the same presumptive drug tests as the HCPCS G-codes, the Centers for Medicare & Medicaid Services (CMS) assigned these new CPT codes to the same OPPS status indicator as its predecessor HCPCS G-codes effective January 1, 2017. Table 2 shows the HCPCS codes, long descriptors, status indicators, and replacement codes for the HCPCS G-codes.

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Table 2 - Coding changes for presumptive drug tests effective January 1, 2017

HCPCS	Long Desc.	OPPS SI	Add Date	Termination date	Replacement code
G0477	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service	N/A	01/01/2016	12/31/2016	80305
G0478	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service	N/A	01/01/2016	12/31/2016	80306
G0479	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, tof, maldi, ldtd, desi, dart, ghpc, gc mass spectrometry), includes sample validation when performed, per date of service	N/A	01/01/2016	12/31/2016	80307
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service	Q4	01/01/2017		N/A
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); read by instrument assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service	Q4	01/01/2017		N/A
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., eia, elisa, emit, fpia, ia, kims, ria]), chromatography (e.g., gc, hplc), and mass spectrometry either with or without chromatography, (e.g., dart, desi, gc-ms, gc-ms/ms, lc-ms, lc-ms/ms, ldtd, maldi, tof) includes sample validation when performed, per date of service	Q4	01/01/2017		N/A

Because CMS was unable to delete HCPCS codes G0477, G0478 and G0479 in the January 2017 I/OCE update, CMS is deleting these codes in the April 2017 I/OCE update effective December 31, 2016. The short descriptors for CPT codes 80305, 80306 and 80307, along with their status indicators, are available in the April 2017 OPPS Addendum B.

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Clarification regarding HCPCS code G0498

Under the OPPS, HCPCS code G0498 is assigned status indicator "S" (Procedure or Service, Not discounted when multiple) effective January 1, 2016. HCPCS code G0498 (Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/other outpatient setting using office/other outpatient setting pump/supplies, with continuation of the infusion in the community setting (for example, home, domiciliary, rest home or assisted living) is intended to describe a service where the facility incurred a facility expense specific to the provision of the non-implantable, external infusion pump.

Because HCPCS code G0498 includes the chemotherapy administration, providers should not report HCPCS code G0498 with CPT® code 96416 (Initiation of prolonged chemotherapy infusion - more than 8 hours - requiring use of a portable or implantable pump). In addition, a hospital should append modifier 52 (reduced service) to HCPCS code G0498 when a component of the service is not performed.

As a reminder, hospitals are expected to report all drug administration CPT® codes in a manner consistent with their descriptors, CPT® instructions and correct coding principles. Also, hospitals are reminded to bill for all services provided using the HCPCS code(s) that most accurately describe the service(s) they provided.

Argus retinal prosthesis add-on code (C1842)

As stated in the January 2017 update, HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add-on to C1841) was established to resolve a claims processing issue for Ambulatory Surgery Centers (ASC) and should not be reported on institutional claims by hospital outpatient department providers. Therefore, the status indicator for HCPCS code C1842 will change from status indicator (SI)=N (Paid under OPPS; payment is packaged into payment for other services) to SI=E1 (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type) in the April 2017 update. This correction to status indicator will be retroactive to January 1, 2017.

Drugs, biologicals and radiopharmaceuticals

A. Drugs and biologicals with payments based on average sales price (ASP) Effective April 1, 2017

For 2017, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical.

In 2017, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead cost of these pass-through items.

Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2017, and drug price restatements are available in the April 2017 update of the OPPS Addendum A and Addendum B.

B. Drugs and biologicals with OPPS pass-through status effective April 1, 2017

Seven drugs and biologicals have been granted OPPS pass-through status effective April 1, 2017. These items, along with their descriptors and ambulatory payment classification (APC) assignments, are identified in Table 3.

Table 3 – Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2017

HCPCS code	Long desc.	APC	Status ind.
C9484	Injection, eteplirsen, 10 mg	9484	G
C9485	Injection, olaratumab, 10 mg	9485	G
C9486	Injection, granisetron extended release, 0.1 mg	9486	G
C9487	Ustekinumab, for intravenous injection, 1 mg	9487	G
C9488	Injection, conivaptan hydrochloride, 1 mg	9488	G
J7328	Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg	1862	G
Q5102	Injection, infliximab, biosimilar, 10 mg	1847	G

C. 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 at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html* on the first date of the quarter. Providers may

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resubmit claims that were impacted by adjustments to previous quarter's payment files.

D. Revised Status Indicator for HCPCS Code J1130

The status indicator for HCPCS code J1130 (Injection, diclofenac sodium, 0.5 mg) will change from SI=E2 (Items and Services for which pricing information and claims data are not available) to SI=K (Paid under OPPS; separate APC payment) in the April 2017 update. This correction to status indicator will be retroactive to January 1, 2017. See Table 4.

Table 4 – Revised Status Indicator for HCPCS Code J1130

HCPCS code	Long desc	APC	Status Ind.	Effective date
J1130	Injection, diclofenac sodium, 0.5 mg	1863	K	01/01/2017

E. HCPCS code C9744

As a reminder to hospital providers, HCPCS code C9744 (Ultrasound, abdominal, with contrast) may be used to describe use of a contrast agent in ultrasonography of the liver, kidneys and/or bladder.

F. Reassignment of skin substitute product from the low cost group to the high cost group

Four skin substitute products have been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The HCPCS codes are Q4161, Q4169, Q4173 and Q4175. These products are listed in Table 5.

Table 5 – Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group Effective April 1, 2017

2017 HCPCS code	2017 Short Desc	2017 SI	Low/High cost skin substitute
Q4161	Bio-Connekt per square cm	N	High
Q4169	Artacent wound, per square cm	N	High
Q4173	Palingen or palingen xplus, per sq cm	N	High
Q4175	Miroderm, per square cm	N	High

G. Removal of skin substitute product from the high/low cost skin substitute table

One HCPCS code, Q4171, was inadvertently included in the High/Low Cost Skin Substitute table. Effective April 2017, Q4171 is removed from the High/Low Cost Skin Substitute table. This product is listed in Table 6.

Table 6 – Skin Substitute Product removed from High/Low Cost Skin Substitute Table Effective April 1, 2017

2017 HCPCS code	2017 Short desc	2017 SI
Q4171	Interfyl, 1 mg	N

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. Instead, it only indicates how the product, procedure or service may be paid if covered by the program. Medicare administrative contractors (MAC) determine whether a drug, device, procedure or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 10005 issued to your MAC regarding this change, refer to *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3728CP.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: MM10005
Related Change Request (CR) #: CR 10005
Related CR Release Date: March 3, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3728CP
Implementation Date: April 3, 2017

New MSP type for liability set-aside arrangements

Provider types affected

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

What you need to know

This article is based on change request (CR) 9893. To comply with the Government Accountability Office (GAO) final report entitled *Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333)*, the Centers for Medicare & Medicaid Services (CMS) will establish two new set-aside processes: a liability insurance Medicare set-aside arrangement (LMSA), and a no-fault insurance Medicare set-aside arrangement (NFMSA).

An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare.

Please be sure your billing staffs are aware of these changes.

Background

CMS will establish two (2) new set-aside processes: a Liability Medicare Set-aside Arrangement (LMSA), and a No-Fault Medicare Set-aside Arrangement (NFMSA).

CR 9893 addresses (1) the policies, procedures, and system updates required to create and utilize an LMSA and an NFMSA MSP record, similar to a Workers' Compensation Medicare set-aside arrangement (WCMSA) MSP record, and (2) instructs the MACs and shared systems when to deny payment for items or services that should be paid from an LMSA or an NFMSA fund.

Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA or NFMSA funds. However, Liability and No- Fault MSP claims that do not have a Medicare Set-Aside Arrangement (MSA) will continue to be processed under current MSP claims processing instructions.

Key points of CR 9893

Medicare will not pay for those services related to the diagnosis code (or related within the family of diagnosis codes) associated with the open LMSA or NFMSA MSP record when the claim's date of service is on or after the MSP effective date and on or before the MSP termination date. Your MAC will deny such claims using claim adjustment reason code (CARC) 201 and group code "PR" will be used when denying claims based on the open LMSA or NFMSA MSP auxiliary record.

In addition to CARC 201 and Group Code PR, when denying a claim based upon the existence of an open LMSA or NFMSA MSP record, your MAC will include the following Remittance Advice Remark Codes (RARCs) as appropriate to the situation:

- N723—Patient must use Liability Set Aside (LSA) funds to pay for the medical service or item.
- N724—Patient must use No-Fault Set-Aside (NFSA) funds to pay for the medical service or item.

Where appropriate, MACs may override and make payment for claim lines or claims on which:

- Auto/no-fault insurance set-asides diagnosis codes do not apply, or
- Liability insurance set-asides diagnosis codes do not apply, or are not related, or When the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in CR 9009.

On institutional claims, if the MAC is attempting to allow payment on the claim, the MAC will include an "N" on the '001' Total revenue charge line of the claim.

Additional information

The official instruction, CR 9893, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1787OTN.pdf*.

The GAO report related to this issue is available at *http://www.gao.gov/products/GAO-12-333*.

CR 9009 is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R113MSP.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: MM9893
Related Change Request (CR) #: CR 9893
Related CR Release Date: February 3, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1787OTN
Implementation Date: October 2, 2017

Medicare travel allowance fees for collection of clinical laboratory specimens

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.

Provider action needed

Change request (CR) 9960 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for 2017. Make sure that your billing staffs are aware of these changes.

Background

The travel codes allow for payment either on a per mileage basis (P9603) or on a flat-rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. MAC discretion allows the contractor to choose either a mileage basis or a flat rate, and how to set each type of allowance.

Because audits have shown that some laboratories abused the per mileage fee basis by claiming travel mileage in excess of the minimum distance necessary for a laboratory technician to travel for specimen collection, many MACs established local policy to pay based on a flat-rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip. This applies to both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the MAC.

• Per Mile Travel Allowance (P9603) - The per mile travel allowance is to be used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using the Federal mileage rate of $0.535 per mile plus an additional $0.45 per mile to cover the technician's time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $0.99 per mile ($0.985 is rounded up for system purposes) if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the Clinical Laboratory Fee Schedule (CLFS), as needed.

At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

Per Flat-Rate Trip Basis Travel Allowance (P9604) - The per flat-rate trip basis travel allowance is $9.85.

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.

Additional information

The official instruction, CR 9960, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3717CP.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: MM9960
Related Change Request (CR) #: CR 9960
Related CR Release Date: February 10, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3717CP
Implementation Date: May 12, 2017

April 2017 update to the Medicare physician fee schedule database

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 and subject to the Medicare physician fee schedule (MPFS).

Provider action needed

Change request (CR) 9977 informs MACs about changes to the MPFS payment files. While the changes will be implemented in Medicare systems on April 3, the changes are effective January 1, 2017. Note that MACs need not search their files to either retract payment for claims already paid or to retroactively pay claims already processed. However, the MACs will adjust such claims that you bring to their attention. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to the MACs based upon the 2017 MPFS Final Rule, published in the *Federal Register* on November 15, 2016, to be effective for services furnished between January 1, 2017, and December 31, 2017.

Below is a summary of the changes for the April update to the 2017 MPFSDB. These changes are effective for dates of service on or after January 1, 2017

CPT®/HCPCS Code	MOD	Action
G0477		Procedure Status = I
G0478		Procedure Status = I
G0479		Procedure Status = I
22867		Assistant surgery indicator = 2
22869		Assistant surgery indicator = 2
76519	26	Bilateral surgery indicator = 3
92136	26	Bilateral surgery indicator = 3
97161		Non-facility & facility PE RVU = 1.00
97162		Non-facility & facility PE RVU = 1.00
97163		Non-facility & facility PE RVU = 1.00
97165		Non-facility & facility PE RVU = 1.32
97166		Non-facility & facility PE RVU = 1.32
97167		Non-facility & facility PE RVU = 1.32
97168		Non-facility & facility PE RVU = 0.93

In addition, the following new codes have been added to the HCPCS file effective February 1, 2017. The HCPCS file coverage code is C (carrier judgment) for these new codes. Coverage and payment will be determined by the MAC (they are not part of the MPFS).

CPT® code	Short descriptor	Long descriptor
0001U	RBC DNA HEA 35 AG 11 BLD GRP	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported
0002U	ONC CLRCT 3 UR METAB ALG PLP	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps
0003U	ONC OVAR 5 PRTN SER ALG SCOR	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score

Additional information

The official instruction, CR 9977, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-guidance/Guidance/Transmittals/2017Downloads/R3719CP.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: MM9977
Related Change Request (CR) #: CR 9977
Related CR Release Date: February 15, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3719CP
Implementation Date: April 3, 2017

April 2017 quarterly update for 2017 DMEPOS fee schedule

Provider types affected

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

What you need to know

Change request (CR) 9988 provides the April 2017 quarterly update for the Medicare DMEPOS fee schedule, and it includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Pub.100-04, Chapter 23, Section 60).

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (§1834(a), (h), and (i)). Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, Section §1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME.

The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments.

Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

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

The 2017 DMEPOS and PEN fee schedules and the April 2017 DMEPOS Rural ZIP code file public use files (PUFs) will be available for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the data files at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched*.

KU modifier for complex rehabilitative power wheelchair accessories & seat and back cushions

Section 16005 of the 21st Century Cures Act extends the effective date through June 30, 2017, to exclude adjustments to fees using information from CBPs for certain wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). As a result, the KU modifier fees have been added back to the DMEPOS fee schedule file effective January 1, 2017, and are effective for dates of service through June 30, 2017.

The fees for items denoted with the HCPCS modifier 'KU' represent the unadjusted fee schedule amounts (the 2015 fee schedule amount updated by the 2016 and 2017 DMEPOS covered item update factor of 0.7 percent). The applicable complex rehabilitative wheelchair accessory codes are listed in CR 9520 (Transmittal 3535, dated June 7, 2016).

Note for change request 8822 reclassification of certain DME to the capped rental payment category

For dates of service on or after January 1, 2017, payment for the following HCPCS codes in all geographic areas is made on a capped rental basis: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.

For dates of service on or after July 1, 2016, through December 31, 2016, these HCPCS codes were reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the nine Round 1 Recompete (Round 1 2014) Competitive Bidding Areas (CBAs). Program instructions on these changes were issued in CR 8822 (Transmittal 1626, dated February 19, 2016) and CR

See **DMEPOS**, on page 30

Episode payment model operations

Provider types affected

This *MLN Matters*® article is intended for physicians and acute care hospitals that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

In August 2016, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule that planned to implement an additional set of models that share many design features of the comprehensive care for joint replacement (CJR) model, but focus on three different clinical conditions. The new episode payment models (EPMs) will focus on acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip and femur fracture treatment (SHFFT), most frequently hip pinning.

These models will begin in 2017 and run for 5 years.

Change request (CR) 9916 is intended to prepare Medicare's claims processing systems for implementation of episode payment models (EPMs). CR 9916 directs the MACs to conduct beneficiary eligibility checks, including for overall eligibility for the EPMs as well as for additional related services such as post-discharge home visits Under EPM, CMS will allow a beneficiary in certain EPM episodes to receive skilled nursing facility (SNF) services without having to meet the three-day requirement in performance years two through five of the model. This will allow payment of claims for SNF services delivered to beneficiaries at eligible sites.

Background

The Social Security Act (Section 1115A) authorizes CMS to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. CMS has previously used its legislative authority to create payment models, such as the bundled payments for care improvement (BPCI) initiative, to test bundled payments.

In April 2016, CMS began testing a new bundled payment model called the comprehensive care for joint replacement (CJR) model. The CJR Model requires that hospitals test bundled payments for lower extremity joint replacement (LEJR) episodes in multiple geographic areas. The CJR model is designed to promote quality and financial accountability for episodes of care surrounding a LEJR and test whether bundled payments to acute care hospitals for LEJR episodes of care can reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

In December 2016, CMS published a final rule that implements an additional set of models that share many design features of the CJR Model, but focus on three different clinical conditions, namely:

- Acute myocardial infarction (AMI),
- Coronary artery bypass graft (CABG), and
- Surgical hip and femur fracture treatment (SHFFT), most frequently hip pinning.

These models will begin in 2017 and run for five performance years (PY).

- PY1: July 1, 2017 – December 31, 2017
- PY2: January 1, 2018 - December 31, 2018
- PY3: January 1, 2019 - December 31, 2019
- PY4: January 1, 2020 - December 31, 2020
- PY5: January 1, 2021 - December 31, 2021

Under the EPMs, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for AMI, CABG, and/or SHFFT episodes. All related care within 90 days of hospital discharge will be included in the episode of care.

The final rule also finalized the concurrent implementation of a cardiac rehabilitation incentive payment (CR) model. The CR Model will provide incentive payments to hospitals that discharge patients following an AMI or CABG with referral to cardiac rehabilitation/intensive cardiac rehabilitation, an underutilized but effective treatment for patients recovering from an acute cardiac event. Incentive payments will be tied to the number of cardiac rehabilitation/intensive cardiac rehabilitation visits that the patient completes. The CR model will be implemented in two separate cohorts in order to test its efficacy, one in the same regions as the AMI and CABG models, and one in purely fee-for-service (FFS) regions.

EPM episodes of care

Medicare currently pays for AMI, CABG, and SHFFT procedures under the Inpatient Prospective Payment System (IPPS) through Medicare severity diagnosis related groups (MS-DRGs). Under the EPMs, episodes would begin with admission to an acute care hospital when a claim is assigned to an MS-DRG included in one of the EPMs upon beneficiary discharge and paid under the IPPS, and would end 90 days after the date of discharge from the acute care hospital. The episode would include the inpatient procedure, inpatient stay, and all related care as defined under the model that is covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care, and physician services.

EPM participants

Participants would be acute care hospitals, who would be the episode initiators (that is, the entity where the episode begins) and bear quality and episode payment accountability under the EPMs. CMS will require all hospitals paid under the IPPS and located in selected geographic areas to participate in the EPMs, with limited exceptions for those hospitals currently participating in

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BPCI model 2 or model 4 for the same clinical episodes. The care for eligible beneficiaries who receive care at these hospitals will automatically be included in the model.

EPM model beneficiary inclusion criteria

The defined population of Medicare beneficiaries whose care will be included in the EPMs must meet the following criteria upon admission to the anchor hospitalization:

• The beneficiary is enrolled in Medicare Part A and Part B throughout the duration of the episode.

• The beneficiary's eligibility for Medicare is not on the basis of the End Stage Renal Disease (ESRD) benefit.

• The beneficiary is not prospectively assigned to an accountable care organization (ACO) in the next generation ACO model, an ACO in a track of the comprehensive ESRD care model incorporating downside risk for financial losses, or a Shared Savings Program ACO in Track 3.

• The beneficiary is not enrolled in any managed care plan.

• The beneficiary is not covered under a United Mine Workers of America health plan.

• Medicare is the primary payer.

EPM episode reconciliation activities

CMS will continue paying hospitals and other providers according to the conventional Medicare FFS rules during all performance years. After each performance year, the Medicare payments for services included in the episode for an EPM beneficiary will be aggregated to calculate an actual episode payment. The actual episode payment will then be compared against an established EPM target price that reflects a discount over expected episode spending based on a blend of hospital-specific and regional historical episode data.

Based on this comparison and taking into consideration episode quality performance based on the composite quality score calculated for each hospital each performance year, CMS will determine whether reconciliation payment to (applicable for PYs 1-5) or recoupment from (applicable for some hospitals PYs 3-5 and other hospitals PYs 2-5) the hospital will be conducted. In addition, in order to be eligible for a reconciliation payment, the hospital must meet the applicable minimum composite quality score. Calculation of these reconciliation or recoupment amounts will be conducted by a specialty contractor annually and paid or recouped beginning in 2018.

Identifying EPM claims

To validate the retroactive identification of EPM episodes, CMS is associating the Demonstration Code 79 with the EPM initiative. This code will be used to operationalize the waiver of the 3-day stay requirement for covered SNF services. This waiver will be effective in conjunction with the introduction of downside risk to the AMI episodes ending on or after January 1, 2019 (and beginning on or after 10/4/2018) and it will allow for the payment of SNF Claims for beneficiaries who have not met the 3-day hospital stay requirement for claims containing the Demonstration code 79.3

SNF 3-Day waiver

In order to provide more comprehensive care across the post-acute spectrum and support the ability of participant hospitals to coordinate the care of beneficiaries, CMS will conditionally waive the 3-day stay requirement for beneficiaries for covered SNF services in AMI EPM episodes, effective with AMI EPM episodes that start on or after payment year three of the model (January 1, 2019).

Under Medicare rules, in order for Medicare to pay for SNF services, a beneficiary must have a qualifying hospital stay of at least three consecutive days (counting the day of hospital admission but not the day of discharge). Additional information regarding the SNF benefit is available in the *Medicare Benefit Manual*, (Pub 100–02, Chapter 8, Skilled Nursing Facility Services).

As of October 4, 2018, CR9916 allows for payment of SNF claims without a 3-day hospital stay (that is, CMS will waive the 3-day hospital stay requirement when all of the following conditions are met:

• The hospitalization does not meet the prerequisite hospital stay of at least 3 consecutive days for Part A coverage of extended care services in a SNF. If the hospital stay would lead to covered SNF services in the absence of the waiver, then the waiver is not necessary for the stay.

• The discharge is from a hospital participating in an EPM. Participants can be confirmed by a posted file on the CMS website and will be shared with MACs on a monthly basis.

The beneficiary must have been discharged from the EPM hospital for one of the specified MS–DRGs (231-236, 246-251, 280-282) within 30 days prior to the initiation of SNF services. (Note that this list of MS-DRGs may need to be updated prior to October 4, 2018 if annual changes to the IPPS MS-DRGs add, combine or delete any of these DRGs.)

• The beneficiary meets the criteria for inclusion in an EPM at the time of SNF admission: That is, he or she is enrolled in Part A and Part B, eligibility is not on the basis of ESRD, is not enrolled in any managed care plan, is not covered under a United Mine Workers of American health plan, is not prospectively assigned to an ACO in the next generation ACO model, an ACO in a track of the

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comprehensive ESRD care model incorporating downside risk for financial losses, or a shared savings program ACO in Track 3, and Medicare is the primary payer.

• The waiver will apply if the SNF is qualified to admit EPM beneficiaries under the waiver. A list of qualified SNFs will be communicated to MACs and CMS Shared Systems Maintainers via a quarterly list, developed by CMS and posted to the CMS website on a quarterly basis. The list will contain those SNFs with an overall star rating of three stars or better for at least 7 of the preceding 12 months of the rolling data used to create the quarterly list.

• The SNF must include demonstration code 79 in the treatment authorization field on claims that qualify for the SNF waiver under the EPM. Note: The waiver is not valid for swing bed (TOB 18X) stays.

• Other requirements. All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply.

Post-Discharge Home Visits

In order for Medicare to pay for home health services, a beneficiary must be determined to be "homebound" and in need of skilled care (skilled nursing, physical therapy or speech-language pathology services). Additional information regarding the home health benefit is available in the *Medicare Benefit Manual* (Pub 100–02, Chapter 7, Home Health Services.)

Medicare policy allows physicians and non-physician practitioners (NPPs) to furnish and bill for visits to any beneficiary's home or place of residence under the physician fee schedule (PFS). Medicare policy also allows licensed clinical staff to furnish services "incident to" the physician or NPP visit at a beneficiary's home when such services are provided under the direct supervision of the physician or NPP.

Licensed clinical staff may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform ordered services. Additional information regarding the "incident to" requirements is available in the *Medicare Benefit Manual* (Pub 100–02, Chapter 15, Covered Medical and Other Health Services, Sections 60-60.4.1).

For those EPM beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment but who are not homebound or otherwise eligible for the Medicare home health benefit, CMS will waive the "incident-to" direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence anytime during the episode, subject to the following conditions:

- Licensed clinical staff will furnish the service under the general supervision of a physician or NPP, who may be either an employee or a contractor of the participant hospital.
- Services will be billed under the PFS by the supervising physician or NPP or by the hospital to which the supervising physician has reassigned his or her billing rights. Up to nine post discharge home visits can be billed and paid per beneficiary during each 90-day post-anchor hospitalization EPM episode.
- The service will be billed with HCPCS G-code 9863, which is specific to the AMI, CABG, or SHFFT model home visits for patient assessment. These visits must be performed by clinical staff for an individual not considered homebound, and may include but not necessarily be limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services. The HCPCS G-code is approved for use only in the Medicare approved AMI, CABG, or SHFFT models and may not be billed for a 30-day period covered by a transitional care management code and paid under the PFS.
- The service cannot be furnished to an EPM beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.

As described in the *Medicare Claims Processing Manual* (Pub 100-04, Chapter 12, Sections 40-40.4), Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for the EPMs, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

Additional information on billing and payment for the post-discharge home visit HCPCS G-Code will be available in the July 2017 release of the Medicare physician fee schedule recurring update.

Billing and payment for telehealth services

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The

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service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service.

Additional information regarding Medicare telehealth services is available in the *Medicare Benefit Policy Manual* (Pub 100-02, Chapter 15, Section 270) and the *Medicare Claims Processing Manual* (Pub 100-04, Chapter 12, Section 190).

Under EPM, CMS will allow a beneficiary in an EPM episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in an EPM episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.

- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the EPM model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the EPM model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.
- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the proposed EPM episode definition.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).
- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the EPM model that reflect the home setting.
- For level 4 and 5 EPM telehealth home visits, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient's home during the visit or document the reason that such a high-level visit would not require such personnel.
- Physicians billing distant site telehealth services under these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.
- The facility fee paid by Medicare to an originating site for a telehealth service would be waived if the service was originated in the beneficiary's home.

Additional information on billing and payment for the telehealth home visit HCPCS G-Codes will be available in the July 2017 release of the MPFS recurring update.

Cardiac rehabilitation (CR) incentive payment model billing and payment

CR services are covered by Medicare and have been shown by research to improve health outcomes. However, these cardiac rehabilitation services have been historically under-utilized by Medicare beneficiaries. The CR incentive payment model is designed to provide participant hospitals in 90 different metropolitan statistical areas with incentive payments to encourage the use of cardiac rehabilitation services for beneficiaries in certain MS-DRGs. Providers and suppliers will continue to be paid under the usual Medicare payment system rules and procedures.

Following the end of a model performance year, depending on beneficiaries' utilization of CR/Intensive CR services, participant hospitals may receive an additional incentive payment from Medicare. CMS has provided a waiver of the definition of a physician to include a physician or NPP (defined for the purposes of this waiver as a physician assistant, nurse practitioner, or clinical nurse specialist) in performing specific physician functions in conjunction with the delivery of CR services to EPM-CR and FFS-CR beneficiaries during AMI care periods and CABG care periods.

Additional information

The official instruction, CR 9916, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R169DEMO.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: MM9916
Related Change Request (CR) #: CR 9916
Related CR Release Date: February 17, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R169DEMO
Implementation Date: July 3, 2017

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8566 (Transmittal 1332, dated January 2, 2014).

Related *MLN Matters* articles are at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8822.pdf* and *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8566.pdf*, respectively.

When submitting claims, suppliers that submit claims with more than four modifiers including when the claim is being billed with both the RT (right) and the LT (left) modifiers will include the NU (Purchase of new equipment) or RR (Rental) modifier as appropriate, the RT and LT modifiers and then the 99 modifier to signify that there are additional modifiers in use. On the narrative line, the supplier will include all applicable modifiers including the NU or RR, RT and LT modifiers.

Example

- Procedure code: E2370
- Units of Service = 2
- Modifiers: RR, LT, RT, 99 (RB, KX reported in additional narrative)

Payment for oxygen volume adjustments and portable oxygen equipment

CR 9848 (Transmittal 3679, dated December 16, 2016) titled Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment, updated the "Medicare Claims Processing Manual" (Pub.100-04, chapter 20, section 130.6) to clarify billing when the prescribed amount of stationary oxygen exceeds 4 liters per minute (LPM) and portable oxygen is prescribed. The QF modifier is used to denote when the oxygen flow exceeds 4 LPM and portable oxygen is prescribed.

The Social Security Act (§ 1834(a)(5)(C) and (D)) requires that when there is an oxygen flow rate that exceeds 4 LPM that the Medicare payment amount be the higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1392) or the portable oxygen add-on amount (E0431, E0433, E0434, E1392, or K0738), and never both.

To facilitate this payment calculation, the QF modifier is added to the DMEPOS fee schedule file effective April 1, 2017, for both stationary and portable oxygen. The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen QF fee schedule amounts represent the higher of 50 percent of the monthly stationary oxygen payment amount or the fee schedule amount for the portable oxygen add-on amount.

Effective April 1, 2017, the modifier "QF" should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 liters per minute (LPM).

Additional information

The official instruction, CR 9988 issued to your MAC regarding this change, refer *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3729CP.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	Description
March 6, 2017	Article released

MLN Matters® Number: MM9988
Related Change Request (CR) #: CR 9988
Related CR Release Date: March 3, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3729CP
Implementation Date: April 3, 2017

ICD-10 coding revisions to national coverage determination

Provider types affected

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

Provider action needed

Change Request (CR) 9861 is the 10th maintenance update of ICD-10 conversions and other coding updates specific to national coverage determinations (NCDs).

The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, CR 8691, CR 9087, CR 9252, CR 9540, CR 9631, and CR 9751; while others are the result of revisions required to other NCD-related CRs released separately. *MLN Matters*® *articles* MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, MM9540, MM9631, MM9751 contain information pertaining to these CR's.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies.

In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. There may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable, as of October 1, 2015.

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

CR 9861 makes adjustments to the following 16 NCDs:

- NCD 40.1 - Diabetes Outpatient Self-Management Training
- NCD 40.7 - Outpatient Intravenous Insulin Treatment
- NCD 80.2 - Photodynamic Therapy (also NCD 80.2.1, 80.3, 80.3.1)
- NCD 80.11 - Vitrectomy
- NCD 100.1 - Bariatric Surgery
- NCD 110.4 – Extracorporeal Photopheresis
- NCD 110.18 - Aprepitant
- NCD 110.23 - Stem Cell Transplantation
- NCD 180.1 - Medical Nutrition Therapy
- NCD 190.1 – Histocompatibility Testing
- NCD 210.3 - Colorectal Cancer Screening
- NCD 220.4 - Mammograms
- NCD 220.6.17 - Positron Emission Tomography (PET) for Solid Tumors
- NCD 260.3.1 - Islet Cell Transplants
- NCD 260.5 - Intestinal and Multi-Visceral Transplants
- NCD 270.6 - Infrared Therapy Devices

The spreadsheets for the above NCDs are available at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9861.zip*.

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

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: remittance advice remark code (RARC) N386 with claim adjustment reason code (CARC) 50, 96, and/or 119, with group code PR (Patient Responsibility) or group code CO (Contractual Obligation), as appropriate.

Your MAC will not search their files to adjust previously processed claims but will adjust any claims that you bring to their attention if found appropriate to do so.

Additional information

The official instruction, CR 9861, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1792OTN.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: MM9861
Related Change Request (CR) #: CR 9861
Related CR Release Date: February 3, 2017
Effective Date: October 1, 2016 - Unless otherwise noted in individual requirements
Related CR Transmittal #: R1792OTN
Implementation Date: March 3, 2017 - MAC local systems; April 3, 2017 - FISS, MCS, CWF Shared systems

Remittance and claims adjustment reason code update

Provider types affected

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

What you need to know

Change request (CR) 9878 updates the remittance advice remark code (RARC) and claim adjustment reason code (CARC) lists. CR 9878 also calls for an update to Medicare remit easy print (MREP) and PC Print software. If you use MREP and/or PC Print software, be sure to obtain the latest version that is released on or before July 3, 2017. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that is published three times per year – around March 1, July 1, and November 1.

CR 9878 provides notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare's shared system maintainers (SSMs) have the responsibility to implement code deactivation, 1) making sure that any deactivated code is not used in original business messages, and 2) allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in CR 9878, MACs must implement on the date specified on the WPC website.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not

match the CMS release schedule. For CR 9878, MACs and SSMs must determine the changes that are included on the code list since the last code update CR (CR 9774) or its corresponding MM Article (MM9774).

Additional information

The official instruction, CR 9878, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3725CP.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: MM9878
Related Change Request (CR) #: CR 9878
Related CR Release Date: February 24, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3725CP
Implementation Date: July 3, 2017

Check the status of claim redeterminations online

Don't wait up learn the status of your appeal. You may check on its status at your convenience -- online, which enables providers to check the status on active redeterminations to confirm if the appeal has been received by First Coast Service Options.

ICD-10 coding revisions to national coverage determinations

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

What you need to know

Change request (CR) 9982 is the 11th maintenance update of ICD-10 conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, CR 8691, CR 9087, CR 9252, CR 9540, CR 9631, CR 9751, and CR 9861; while others are the result of revisions required to other NCD-related CRs released separately. *MLN Matters*® articles MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, MM9540, MM9631, MM9751, and MM9861 contain information pertaining to these CRs.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete general equivalence mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies.

In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. There may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable, as of October 1, 2015.

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

CR 9982 makes coding and clarifying adjustments to the following NCDs:

- NCD20.31 - Intensive Cardiac Rehabilitation (ICR)
- NCD20.31.1 - ICR Pritkin Program
- NCD20.31.2 - ICR Ornish Program
- NCD20.31.3 - ICR Benson-Henry Program
- NCD20.34 - Left Atrial Appendage Closure
- NCD190.3 - Cytogenetic Studies
- NCD260.3.1 - Islet Cell Transplants in Clinical Trials
- NCD270.1 - Electrical Stimulation & Electromagnetic Therapy for Treatment of Wounds
- NCD220.4 – Mammograms

The spreadsheets for the above NCDs are available at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9982.zip*.

Please remember that coding and payment areas of the Medicare program are separate and distinct from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services (CMS) and are not intended to change the original intent of the NCD.

The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate. MACs will complete all tasks that involve updates to local system edits/tables associated with the attached NCDs in this CR.

MACs will use default CAQH CORE messages where appropriate:

- RARC N386 with CARC 50, 96, and/or 119. See latest CAQH CORE update at *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

When denying claims associated with the attached NCDs, except where otherwise indicated, A/B MACs will use:

- Group code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed ABN is on file).
- Group code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148 available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2148CP.pdf*.

Your MAC will not search their files to adjust previously processed claims but will adjust any claims that you bring to their attention if appropriate to do so.

Additional information

The official instruction, CR 9982, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1798OTN.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-*

See **ICD-10**, on page 34

Healthcare provider taxonomy codes April 2017 update

Provider types affected

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

Provider action needed

Change request (CR) 9869 instructs macs to obtain the most recent healthcare provider taxonomy code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

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

You should note that:

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

CR 9869 implements the NUCC HPTC code set that is effective on April 1, 2017, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

MACs will implement the April 2017 HPTC update as soon as they can after April 1, 2017, but not beyond July 3, 2017. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at *http://www.wpc-edi.com/codes*.

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:

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

Additional information

The official instruction, CR 9869, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3723CP.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: MM9869
Related Change Request (CR) #: CR 9869
Related CR Release Date: February 24, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3723CP
Implementation Date: July 3, 2017

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Programs/Review-Contractor-Directory-Interactive-Map/.

MLN Matters® Number: MM9982
Related Change Request (CR) #: CR 9982
Related CR Release Date: February 17, 2017
Effective Date: July 1, 2017 (Unless otherwise noted in individual NCDs)
Related CR Transmittal #: R1798OTN
Implementation Date: March 20, 2017, for MAC edits and July 3, 2017, for Shared Systems

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Implementation of new influenza virus vaccine code

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.

What you need to know

Change request (CR) 9876 provides instructions for payment and edits for the common working file (CWF) to include influenza virus vaccine code 90682 (Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use) for claims with dates of service on or after July 1, 2017. Make sure that your billing staffs are aware of these instructions.

Background

Effective for dates of service on and after July 1, 2017, influenza virus code 90682 will be payable by Medicare. Annual Part B deductible and coinsurance amounts do not apply to this code. MACs will:

- Effective for dates of service on or after August 1, 2017, MACs will pay for code 90682 using the Centers for Medicare & Medicaid Services (CMS) seasonal influenza vaccines pricing at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* to determine the payment rate for influenza virus vaccine code 90682.
- Pay for vaccine code 90682 on institutional claims as follows:
    - Hospitals – types of bill (TOB) 12x and 13x, skilled nursing facilities (SNFs) – TOB 22x and 23x, home health agencies (HHAs) – TOB 34x, hospital-based renal dialysis facilities (RDFs) – TOB 72x, and critical access hospitals (CAHs) – TOB 85x, based on reasonable cost
    - Indian health service (IHS) hospitals – TOB 12x, and 13x, IHS CAHs – TOB 85x, and hospices (81x and 82x) based on the lower of the actual charge or 95 percent of the average wholesale price (AWP)
    - Comprehensive outpatient rehabilitation facility (CORF) – TOB 75x, and independent RDFs – TOB 72x, based on the lower of actual charge or 95 percent of the AWP
- MACs will pay at discretion claims for code 90682 with dates of service July 1, 2017, through July 31, 2017.
- MACs will return to the provider (RTP) institutional claims if submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017.
- MACs will deny Part B claims submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017, using the following messages:
    - Claim adjustment reason code: 181 – "Procedure code was invalid on the date of service."
    - Remittance advice remark code: N56 – "Procedure code billed is not correct/valid for the services billed or the date of service billed."
    - Group code: CO (Contractual Obligation)

In addition, effective for claims with dates of service on or after October 1, 2016, MACs will pay vaccines (Influenza, PPV, and HepB) to hospices based on the lower of the actual charge or 95 percent of AWP. Coinsurance and deductibles do not apply. Further, MACs will adjust previously processed hospice claims (TOB 81x or 82x) for these vaccines with dates of service on or after October 1, 2016.

Additional information

The official instruction, CR 9876, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3711CP.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: MM9876
Related Change Request (CR) #: CR 9876
Related CR Release Date: February 3, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3711CP
Implementation Date: July 3, 2017

Upcoming provider outreach and educational events

Medicare Te Informa 2017 Dorado

Date: April 20-21, 2017
Time: 8:00 AM-3:30 PM
Type of Event: Face-to-face
https://medicare.fcso.com/Medicare_te_informa/0368651.asp

E/M Services: Documenting Nursing Facility Visits (B)

Date: Tuesday, April 25, 2017
Time: 10:00-11:30 AM
Type of Event: Webcast
https://medicare.fcso.com/Events/0371066.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.

MLN Connects®

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

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 February 23, 2017

MLN Connects® for February 23, 2017

View this edition as a PDF

News & Announcements

- CMS Awards Approximately $100 Million to Help Small Practices Succeed in the Quality Payment Program
- NHSN Data Submission Deadline for IRF and LTCH QRP: Extended to May 15

Provider compliance

- Reporting Changes in Ownership

Upcoming Events

- SNF VBP: Understanding Your Facility's Confidential Feedback Report Call — March 15
- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Comparative Billing Report on Physical Therapy Webinar — March 29

Medicare Learning Network® Publications & Multimedia

- Collecting Data on Sexual Orientation and Gender Identity in Health Care Settings Web-Based Training Course — New
- Audio Recordings and Transcripts from Recent Calls — New
- Medicare Outpatient Observation Notice Instructions MLN Matters Article — Revised
- Acute Care and the IPPS Web-Based Training Course — Revised

MLN Connects® for March 2, 2017

MLN Connects® for March 2, 2017

View this edition as a PDF

News & Announcements

- IRF and LTCH QRP Preview Reports Available: Review by March 30
- March is National Colorectal Cancer Awareness Month

Provider compliance

- Home Health Care: Proper Certification Required

Upcoming Events

- SNF VBP: Understanding Your Facility's Confidential Feedback Report Call — March 15
- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Home Health Quality Reporting Program Provider Training — May 3 and 4

Medicare Learning Network® Publications & Multimedia

- Critical Access Hospital Booklet — Revised
- Transitional Care Management Services Fact Sheet — Revised
- MREP Software Fact Sheet — Reminder
- HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Reminder
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder

MLN Connects® for March 9, 2017

MLN Connects® for March 9, 2017

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News & Announcements

- Social Security Number Removal Initiative: New Details
- Clinical Laboratories: Report Lab Data through March 31
- New Release of PEPPER for Short-term Acute Care Hospitals
- Hospice Quality Reporting Program: Rerun Your Quality Measure Reports
- LTCHs: Exceptions to Moratorium on Increasing Beds
- Therapeutic Continuous Glucose Monitors Classified as Durable Medical Equipment
- Influenza Activity Continues: Are Your Patients Protected?

Provider compliance

- Chiropractic Services: High Improper Payment Rate within Medicare FFS Part B

Claims, Pricers & Codes

- April 2017 Average Sales Price Files Available

Upcoming Events

- SNF VBP: Understanding Your Facility's Confidential Feedback Report Call — March 15
- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Medicare Diabetes Prevention Program Expanded Model Webinar — March 22
- Medicare ACO Track 1+ Model Webinar — March 22
- DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act Call — March 23
- IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29
- Open Payments: Prepare to Review Reported Data Call — April 13

Medicare Learning Network® Publications & Multimedia

- Medicare Enrollment Resources Educational Tool — New
- Chronic Care Management Services Call: Audio Recording and Transcript — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Suite of Products & Resources Educational Tools — Revised
- Federally Qualified Health Center Fact Sheet — Revised
- PECOS for DMEPOS Suppliers Fact Sheet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder
- Advance Care Planning Fact Sheet — Reminder

MLN Connects® for March 16, 2017

MLN Connects® for March 16, 2017

View this edition as a PDF

News & Announcements

- Revised CMS-855O Application: Enrollment Solely to Order, Certify, or Prescribe
- Comparative Billing Report on Sudomotor Function Testing in April
- IRF and LTCH QRP Preview Reports Available: Review by March 30
- Improve Health during National Nutrition Month®

Provider compliance

- Inpatient Skilled Nursing Facility Denials

Claims, Pricers & Codes

- Chronic Care Management Payment Correction for RHCs and FQHCs

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Medicare ACO Track 1+ Model Webinar — March 22
- DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act Call — March 23
- IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29
- Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call — April 6
- Open Payments: Prepare to Review Reported Data Call — April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
- Comparative Billing Report Webinar on Sudomotor-Function Testing — May 10

Medicare Learning Network® Publications & Multimedia

- Rural Health Clinic Fact Sheet — Revised

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

Reconsideration
C2C Innovative Solutions, Inc.
QIC Part A East Appeals
P. O. Box 45305
Jacksonville, FL 32232-5305

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