Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

April 2017

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Payment for moderate sedation services

Provider types affected

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

What you need to know

Change request (CR) 10001 revises existing *Medicare Claims Processing Manual* language to bring the manual in line with current payment policy for moderate sedation and anesthesia services. Providers should refer to the revised *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Sections 50 and 140 for information regarding the reporting of moderate sedation and anesthesia services. The revision is attached to CR 10001. Make sure your billing staff is aware of these revisions.

Key manual changes

General payment rule

The fee schedule amount for physician anesthesia services furnished is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is communicated to the MACs by means of the Healthcare Common Procedure Coding System (HCPCS) file released annually. The Centers for Medicare & Medicaid Services (CMS) releases the conversion factor annually. The base units and conversion factor are available at *https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html*.

Moderate sedation services furnished in conjunction with and in Support of procedural services

Anesthesia services range in complexity. The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia and general anesthesia. Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care.

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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.

Processing Issue

Part A processing issues with pneumococcal and influenza vaccinations

Issue

First Coast has become aware of processing issues for pneumococcal and influenza vaccinations where in some instances the vaccination is not being priced, and in other instances, the vaccination is being priced; however, coinsurance is being applied in error.

Resolution

This problem has been resolved; affected claims are in the process of being mass adjusted. It is anticipated that the adjustments will be completed by March 31, 2017.

Status/date resolved

Closed February 28, 2017

Provider action

None

Current processing issues

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

General Information

Provider enrollment revalidation – cycle 2

***Note**: This article was revised April 10, 2017, to correct the table under "Revalidation timeline and example." The last row should have stated the date as "November 29 – December 14, 2017." All other information is unchanged. This information was previously published in the March 2017 Medicare A Connection, page 4-8.*

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

Stop – impact to you

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 know

Special note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

Go – 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:

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- 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 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 six 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 *https://go.cms.gov/MedicareRevalidation*.

  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 three years for DME suppliers and 5 years for all other providers/suppliers).
- In addition, the MAC will send a revalidation notice within two-three 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 two 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 six 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 to determine their provider/supplier's revalidation due dates.

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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*.

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

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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 six months prior to due date	March 30, 2017
Issue large group notifications	Approximately six 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	November 29 – December 14, 2017

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 five 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 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 two-three 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 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 *https://go.cms.gov/MedicareRevalidation*.

A sample revalidation letter is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf*. A revalidation checklist

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is available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html*.

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

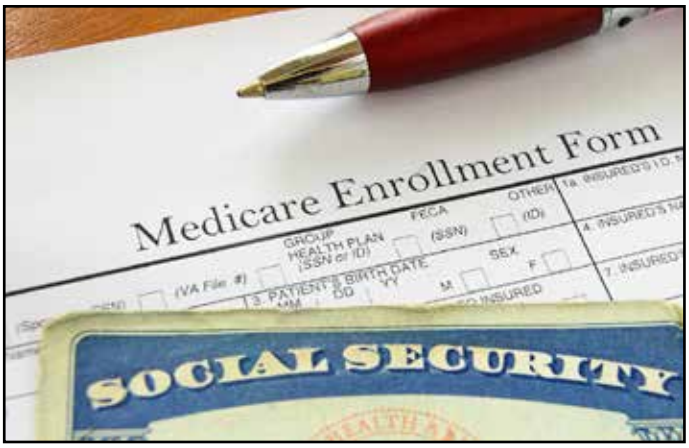
For more information about the application fee payment process, refer to *MLN Matters*® article SE1130, which is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf*.

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 *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf*.

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 web page at *https://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
April 10, 2017	The article was revised to correct the table under “Revalidation timeline and example”. The last row should have stated the date as “ November 29-December 14, 2017.”
March 15, 2017	The updated article revised the table under “Revalidation timeline and example” and added additional information after that table.
February 22, 2016	Initial article released

MLN Matters® Number: SE1605 *Revised*
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Implementation Date: N/A

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USVI provider contact center hours of operation effective March 13

Effective Monday, March 13, 2017, the hours of availability for the provider contact center (PCC) for U.S. Virgin Islands providers are as indicated in this article. The hours for calling into First Coast’s PCC are 8:00 a.m. - 4:00 p.m. atlantic standard time (AST). This change is due to the beginning of daylight saving time (DST) in the United States.

Next generation accountable care organization – AIPBP implementation

Provider types affected

This *MLN Matters*® article is intended for physicians, hospitals, and other providers who are participating in next generation accountable care organization (NGACOs) model and submitting claims to Medicare administrative contractors (MACs) under the all-inclusive population-based payment (AIPBP) alternate payment mechanism for certain services for Medicare beneficiaries.

Provider action needed

Special edition (SE) article SE17011 reminds providers of the implementation of the AIPBP payment mechanism for participating ACOs.

Background

The NGACO model offers ACOs the option to participate in a payment mechanism called AIPBP under which the ACO takes on responsibility for entering into payment arrangements with its providers and paying claims, in place of claims being paid by Medicare's fee-for-service (FFS) systems. The goal of AIPBP is to establish a monthly cash flow for AIPBP-participating ACOs and a mechanism for ACOs to enter payment arrangements with next generation participants and preferred providers. Conceptually, AIPBP builds on population-based payments (PBP) in the Pioneer ACO model and available in the NGACO model, but enables even greater flexibility in establishing payment relationships between the ACO and its providers.

Under AIPBP, participating ACOs will receive a monthly lump-sum payment outside of the FFS system and be responsible for paying next generation participants and preferred providers with whom they have entered into written AIPBP Payment Arrangement agreements. The monthly payment will be based on an estimation of the care that will be provided to aligned beneficiaries in the performance year by AIPBP-participating providers.

Reconciliation will occur following the performance year to true up the monthly payments (based on estimation) versus what AIPBP-participating providers would have been paid under FFS.

All participating providers will continue to submit FFS claims to CMS, which will fully adjudicate the claims, but will not make payment to providers who have agreed to participate in AIPBP except for add-on payments for inpatient hospitals (specifically operating outlier payments, operating disproportionate share hospital [DSH] payments, operating indirect medical education [IME] payments, Medicare new technology payments, and Islet isolation cell transplantation payments.).

ACOs had an annual election to participate in AIPBP from among three alternate payment mechanisms in 2017; the ACO's providers/suppliers and preferred providers will agree to participate on a provider-by-provider basis (that is, not all providers/suppliers, or preferred providers will have claims reduced up to 100 percent). All AIPBP-participating providers will receive a 100-percent reduction to their claims if they see an aligned beneficiary, unless that aligned beneficiary has opted out of medical claims data sharing with the ACO or if the claim is for substance abuse-related services. If an AIPBP-participating provider sees a beneficiary not aligned to an ACO, they would not receive the reduction.

Providers who do not have an AIPBP payment arrangement with an ACO, whether in the ACO or not, will continue to receive normal FFS reimbursements for all the beneficiaries they treat, including aligned beneficiaries. Medicare systems will continue to view providers and beneficiaries as being FFS.

As mentioned, providers continue to submit all FFS claims to CMS, which will make coverage and liability determinations and assess beneficiary liability. Beneficiary liabilities will be calculated based on what Medicare would have paid in absence of AIPBP, and Medicare summary notices (MSNs) should reflect the amount that would have been paid (as is currently done for PBP). Similarly, Medicare will continue to send remittance notices to AIPBP-participating providers (just as they would receive remittance notices if not participating in AIPBP).

Additional information

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

Document history

Date of change	Description
April 20, 2017	Initial article release.

MLN Matters® Number: SE17011
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Effective Date: January 1, 2017
Implementation Date: January 3, 2017

FISS implementation of the restructured clinical lab fee schedule

Note: *This article was revised March 23, 2017, to reflect the revised change request (CR) 9837 issued that day. In the article, the CR release date, transmittal number, and the web address for accessing CR 9837 are revised. All other information remains the same. This information was previously published in the November 2016 Medicare A Connection, page 5.*

Provider Types Affected

This *MLN Matters*® article is intended for clinical laboratory providers submitting claims to Medicare administrative contractors (MACs) for services paid under the clinical lab fee schedule (CLFS) and provided to Medicare beneficiaries.

Provider Action Needed

Change request (CR) 9837 informs MACs about the changes to the fiscal intermediary shared system (FISS) to incorporate the revised CLFS containing the national fee schedule rates. Make sure that your billing staffs are aware of these changes.

Background

Section 216 of Public Law 113-93, the "Protecting Access to Medicare Act of 2014," added Section 1834A to the Social Security Act (the Act). This provision requires extensive revisions to the payment and coverage methodologies for clinical laboratory tests paid under the CLFS. The Centers for Medicare & Medicaid Services (CMS) published the CLFS final rule "*Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule*" (CMS-1621-F) was displayed in the *Federal Register* on June 17, 2016, and was published June 23, 2016, which implemented the provisions of the new legislation.

The final rule set forth new policies for how CMS sets rates for tests on the CLFS and is effective for dates of service on and after January 1, 2018. Beginning January 1, 2017, applicable laboratories will be required to submit private payor rate data to CMS. (See *MLN Matters*® article *SE1619* for further details of the laboratory data reporting requirements.) In general, with certain designated exceptions, the payment amount for a test on the CLFS furnished on or after January 1, 2018, will be equal to the weighted median of private payer rates determined for the test, based on data collected from laboratories during a specified data collection period. In addition, a subset of tests on the CLFS, advanced diagnostic laboratory tests (ADLTs), will have different data, reporting, and payment policies associated with them. In particular, the final rule discusses CMS' proposals regarding:

- Definition of "applicable laboratory" (who must report data under Section 1834A of the Act)
- Definition of "applicable information" (what data will be reported)
- Data collection period
- Schedule for reporting data to CMS
- Definition of ADLT
- Data Integrity
- Confidentiality and public release of limited data
- Coding for new tests on the CLFS
- Phased in payment reduction

Additional information

The official instruction, CR 9837, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3740CP.pdf*.

MLN Matters® article SE1619 has more details at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1619.pdf*.

The final regulation for the revised CLFS is available at *https://www.gpo.gov/fdsys/pkg/FR-2016-06-23/pdf/2016-14531.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

- November 10, 2016 - Initial article released
- March 23, 2017 - Article revised to reflect revised CR 9837. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information remains the same.

MLN Matters® Number: MM9837 *Revised*
Related Change Request (CR) #: CR 9837
Related CR Release Date: March 23, 2017
Effective Date: January 1, 2018
Related CR Transmittal #: R3740CP
Implementation Date: July 3, 2017

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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Before you file an appeal...

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

Before you appeal a denied claim, check out *these resources*.

Revisions to LCDs

Cardiac Part A/B local coverage determinations revised

LCD ID number: L33282 and L36209 (Florida, Puerto Rico/U.S. Virgin Islands)

The following local coverage determinations (LCDs) were revised to include ICD-10-CM diagnosis code Z01.810 in the "ICD-10 Codes that Support Medical Necessity" sections of LCD L33282 (Computed tomographic angiography of the chest, heart and coronary arteries) for CPT® codes 75571, 75572, 75573, 75574, and LCD L36209 (Cardiology – non-emergent outpatient testing: exercise stress test, stress echo, mpi spect, and cardiac pet) for CPT® codes 78451, 78452, 78453, and 78454.

Effective date

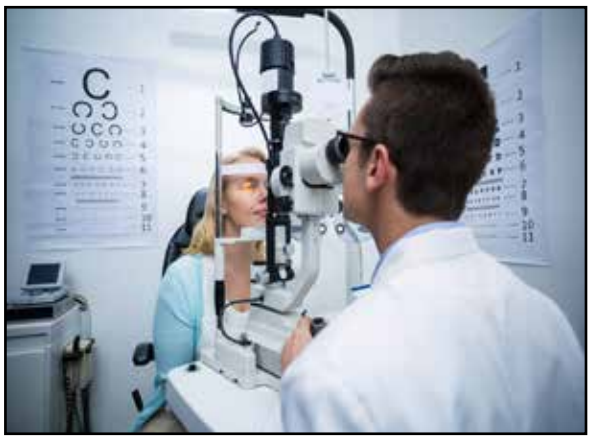
These LCD revisions are effective for claims processed **on or after March 23, 2017**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Optical Part A/B local coverage determinations revised

LCD ID number: L33670 and L34017 (Florida, Puerto Rico/U.S. Virgin Islands)



The following local coverage determinations (LCDs) were revised to include ICD-10-CM diagnosis code range T85.22XA-T85.22XS in the "ICD-10 Codes that Support Medical Necessity" sections of LCD L34017 (Ophthalmoscopy) for *Current Procedural Terminology* (CPT®) codes 92225, 92226 and LCD L33670 (Fundus photography) for CPT® code 92250. In addition, the LCD "Coding Guideline" attachment for LCD L34017 was updated to remove the statement indicating that CPT® codes 92225 and 92226 should not be reported with modifier 50.

Effective date

These LCD revisions are effective for claims processed **on or after March 23, 2017**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

MSI reminder announcement: There is still time to evaluate our services

There is still time to share your experiences about the services we provide. Please complete the MAC Satisfaction Indicator (MSI) survey. These survey results will help us find ways to better serve you. *https://cfigroup.qualtrics.com/jfe/form/SV_3WeVjGWpc5NQXOJ?MAC_BRNC=9&MAC=JN – First Coast*

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

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

Based on change request (CR) 9861 (ICD-10 Coding Revisions to National Coverage Determination [NCDs]), the LCD was revised to add ICD-10-CM diagnosis codes N61.0 and N61.1 for Healthcare Common Procedure Coding System (HCPCS) codes G0204, G0206, and G0279. Although Current Procedural Terminology® (CPT®) codes 77055 and 77056 were deleted effective January 1, 2017, since the addition of diagnosis codes N61.0 and N61.1 is being back-dated to October 1, 2016; these diagnoses are also applicable for CPT® codes 77055 and 77056 for services rendered October 1, 2016-December 31, 2016.

Effective date

This LCD revision is effective for claims processed **on or after April 3, 2017**, for services rendered **on or after October 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

Susceptibility studies – revision to the Part A and Part B LCD

LCD ID number: L33755 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for susceptibility studies was revised to include ICD-10-CM diagnosis codes Z16.10, Z16.11, Z16.12 and Z16.19 in the "ICD-10 Codes that Support Medical Necessity" section of LCD for CPT® codes 87181, 87184, 87185, 87186, 87187, 87188 and 87190. Additionally, clarifying language referencing the *Medicare National Coverage Determination (NCD) Coding Policy Manual*, Section 190.12 – Urine Culture, Bacterial" was added in the "ICD-10 Codes that Support Medical Necessity" section in the LCD.

Effective date

The LCD revision is effective for claims processed **on or after April 5, 2017**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please *click here*.

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 Change Request 10005 (April 2017 Update of the Hospital Outpatient Prospective Payment System [OPPS]). The LCD was revised to add HCPCS code J7328 in the "CPT®/HCPCS Codes" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD for Part A.

Effective date

This LCD revision is effective for services rendered **on or after April 1, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Articles for an LCD (when present) may be found by selecting "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, *click here*.

Update to CWF blood editing on Medicare advantage enrollees' inpatient claims for IME payment

Provider types affected

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

What you need to know

Change request (CR) 10012 informs MACs about the changes to the common working file (CWF) to bypass blood services editing on claims submitted by approved teaching hospitals for Medicare advantage (MA) enrollees for indirect Medicare education (IME) payment type of bill (TOB) 11x, prospective payment system (PPS) indicator Y, condition code 04, and condition code 69. CR 10012 contains no new policy. It improves the implementation of existing Medicare payment policies. Make sure that your billing staffs are aware of these changes.

Background

Approved teaching hospitals submit inpatient claims for MA beneficiaries to their MAC to receive an IME payment and so Original Medicare Part A can include the inpatient days in the Medicare/supplemental security income fraction. Original Medicare Part A does not track utilization of benefits for beneficiaries enrolled in an MA plan. Therefore utilization edits should not apply to an IME only inpatient claim. The Centers for Medicare & Medicaid Services was notified that when an inpatient claim from a teaching hospital for an MA beneficiary is submitted with blood revenue codes, the CWF is setting blood related edits. CR 10012 corrects this problem.

Additional information

To view the official instruction, CR 10012, issued to your MAC regarding this change, refer to *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1819OTN.pdf*.

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

Document history

Date of change	Description
April 7, 2017	Initial article released

MLN Matters® Number: MM10012
Related Change Request (CR) #: CR 10012
Related CR Release Date: April 7, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1819OTN
Implementation Date: October 2, 2017

ANESTHESIA

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Practitioners will report the appropriate CPT® and/or HCPCS code that accurately describes the moderate sedation services performed during a patient encounter, which are performed in conjunction with and in support of a procedural service, consistent with CPT® guidance.

Other manual revisions to Sections 50 and 140

There are other minor revisions to these manual sections and those revised manual sections are attached to CR 10001.

Additional information

Your MAC will not search their files to either retract payment for claims already paid or to retroactively pay claims. They will adjust impacted claims that you bring to their attention.

To view the official instruction, CR 10001 issued to your MAC regarding this change, refer to *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3747CP.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
4/14/17	Initial article released.

MLN Matters® Number: MM10001
Related Change Request (CR) #: CR 10001
Related CR Release Date: April 14, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3747CP
Implementation Date: May 15, 2017

Billing for advance care planning claims

Provider types affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare administrative contractors (MACs) for advance care planning (ACP) services provided as an optional element of the annual wellness visit (AWV) to Medicare beneficiaries.

Provider action needed

Change request (CR) 10000 provides billing instructions for ACP when furnished as an optional element of an AWV. Make sure that your billing staffs are aware of the billing instructions.

Background

The Centers for Medicare & Medicaid Services (CMS) has made the 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 a physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) for ACP separately payable for Medicare OPPS claims when the service meets the criteria for separate payment under OPPS. The change in policy will be implemented through the annual Medicare physician fee schedule database (MPFSDB) update.

ACP with other services

Effective January 1, 2016, payment for the service described by **CPT® code 99497** 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.

ACP service only

When ACP is the only service furnished, payment is made separately.

ACP service with add-on code

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).

ACP service with AWV

CMS is also including voluntary ACP as an optional element of the 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. Additionally, when ACP services are furnished on the same day and by the same provider as an 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 should 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 AWV codes G0438 and code G0439. 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.

Note: The deductible and coinsurance for ACP will only be waived when billed on the same day and on the same claim as an AWV (code G0438 or G0439) and must also be furnished by the same provider. Waiver of the deductible and coinsurance for ACP is limited to once per year. Payment for an AWV is limited to once per year. If the AWV billed with ACP is denied for exceeding the once per

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year limit, the deductible and coinsurance will be applied to the ACP.

Summary of changes

Beginning in 2016, CPT® code 99497 used to describe ACP is conditionally packaged under the OPPS when it is not part of the AWV, 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 is unconditionally packaged (assigned status indicator "N") when it is not part of the AWV.

Beginning in 2016, CPT® codes 99497 and 99498 used to describe ACP will be separately payable under the MPFS for OPPS claims when billed as part of the AWV on the same date of service by the same provider.

Additional information

The official instruction issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3739CP.pdf*.

You may also want to review *MLN Matters*® article *MM9271* (Advance care planning (ACP) as an optional element of an annual wellness visit (AWV)).

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 20, 2017	Initial article release

MLN Matters® Number: MM10000
Related Change Request (CR) #: CR 10000
Related CR Release Date: May 17, 2017
Effective Date: January 1, 2016
Related CR Transmittal #: R3739CP
Implementation Date: June 19, 2017

Quarterly provider update

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

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

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

Your feedback matters

Your opinion is important to us. If you haven't already completed the MAC Satisfaction Indicator (MSI) survey, please take a moment to complete it now. Share your experience with the services we provide. It will take about 10 minutes. You can access the survey by clicking here.

Affordable Care Act - Operating Rules - Requirements for Phase II and Phase III Compliance for Batch Processing

The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing operating rules adopted under Section 1104 of the Affordable Care Act (ACA). The Secretary of the Department of Health & Human Services (HHS) named the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) as the authoring entity of the phase I, II, and III operating rules. The operating rules are intended to provide additional direction and clarification to the electronic data interchange (EDI) standard adopted under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

CMS is currently in the process of implementing the batch requirements for the phase II rules for the claim status inquiry and response, and health care claim payment advice.

HIPAA transactions are referred to in the following manner:

- 276: ASC X12 health care claim status request
- 277: ASC X12 health care information status notification
- 835: ASC X12 health care claim payment/advice

Change request (CR) 9358 requires the MACs to implement a solution to comply with this rule including the use of X.509 client certificates over Secure Socket Layer (SSL) effective April 1, 2017. The solution must be able to receive and post the batch 276/277 and 835 claim payment advice transactions using the public internet. In order to be able to perform these transactions the trading partners must be in compliance with HTTPS CAQH CORE rules. Click *here* for information on the CAQH CORE Connectivity Rule 270 version 2.2.0. For additional information on the CAQH CORE rules click *here*.

First Coast Service Options Inc. (First Coast) will make updates to its EDI enrollment procedures, forms and trading partners' management system for connectivity using the HTTPS CAQH CORE requirements.

Please note that enrollment for these two transactions is optional and must be at the trading partner level. Providers can continue to use their current method of transmission for these and any other EDI transactions.

Source: *MLN Matters® Number MM9358*

Revised CMS-588: Electronic funds transfer authorization agreement

Providers and suppliers must use the revised CMS-588 form (electronic funds transfer authorization agreement) beginning January 1, 2018. The revised form will be posted on the CMS forms list (*https://go.usa.gov/xX3Sa*) by early summer. Medicare administrative contractors will accept both the current and revised versions of the CMS-588 through December 31, 2017. Visit the Medicare provider-supplier enrollment web page (*https://go.usa.gov/xXCWk*) for more information about Medicare enrollment and the electronic funds transfer (EFT) requirements.

Changes to the form include:

- New indicator shows if the EFT is for an individual or a group/organization/corporation in parts 1 and 2 (reason for submission and account holder information)
- Now optional to list the financial institution's contact person
- Four digits added to the *Provider's/Supplier's/Indirect Payment Procedure Entity's Account Number with Financial Institution*, making it consistent with the industry standard

Medicare Learning Network®

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

Modifier JW – discarded drugs from single-use vials or packages

Effective January 1, 2017, the Centers for Medicare & Medicaid Services (CMS) no longer allows contractor discretion with the use of modifier JW (Discarded drugs or biologicals from single use vials or single use packages). Coverage of discarded Part B drugs and biologicals applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts.

- All providers are required to document unused/ discarded drug or biological wastage in the patient's medical record.
- Claims containing drug wastage must be billed using two separate lines:
  - One line represents the portion/dosage administered to the patient
  - The second line (billed with modifier JW) represents the discarded portion.

The JW modifier is not permitted when the actual dose of the drug or biological administered is less than the billing unit. For example: if 7 mg were administered of a 10 mg single use vial, and the 10 mg represents 1 unit, the administered and discarded amounts cannot be split for billing purposes.

CMS encourages physicians to schedule patients in such a way that they can use drugs and biologicals most efficiently. However, if a physician must discard the remainder of a single use vial or other single use package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered, up to the amount of the drug or biological as indicated on the vial or package label.

Sources: *MLN Matters® MM9603*; *"Medicare Claims Processing Manual", Chapter 17, Section 40*

July 2017 quarterly ASP Medicare Part B drug pricing files and revision to prior quarterly pricing files

Provider type 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) 10016 provides the July 2017 quarterly update and instructs MACs to download and implement the July 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised April 2017, January 2017, October 2016, and July 2016 average sales price (ASP) drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 3, 2017, with dates of service July 1, 2017, through September 30, 2017. MACs will not search and adjust claims previously processed unless brought to their attention.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and not otherwise classified (NOC) drug-pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions.

The following files are related to this most recent update:

- July 2017 ASP and ASP NOC – effective dates of service: July 1, 2017, through September 30, 2017
- April 2017 ASP and ASP NOC – effective dates of service: April 1, 2017, through June 30, 2017
- January 2017 ASP and ASP NOC – effective dates of service: January 1, 2017, through March 31, 2017
- October 2016 ASP and ASP NOC – effective dates of services: October 1, 2016, through December 31, 2016
- July 2016 ASP and ASP NOC – effective dates of service: July 1, 2016, through September 30, 2016

For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*. For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing

See **ASP**, next page

Changes to the laboratory NCD edit software for July 2017

Provider type 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) 10036, which announces the changes that will be included in the July 2017 quarterly release of the edit module for clinical diagnostic laboratory services. This is a recurring update notification that applies to *Chapter 16*, Section 120.2, of the *Medicare Claims Processing Manual*. Make sure your billing staffs are aware of these changes.

Background

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (*Medicare National Coverage Manual*, *Sections 190.12 - 190.34*) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, S120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-10-CM codes.

CR 10036 communicates requirements to shared system maintainers (SSMs) and contractors notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for July 2017.These changes become effective for services furnished on or after October 1, 2016, and are as follows:

- ICD-10-CM code R73.03 will be added to the list of ICD-10-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
- ICD-10-CM code R73.03 will be removed from the list of ICD-10-CM codes that are covered by Medicare for the hepatitis panel/acute hepatitis panel (190.33) NCD.

Additional information

The official instruction issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3738CP.pdf*.

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

Document history

Date of change	Description
March 20, 2017	Initial article released

MLN Matters® Number: MM10036
Related CR Release Date: March 17, 2017
Related CR Transmittal Number: R3738CP
Related Change Request (CR) Number: CR10036
Effective Date: October 1, 2016
Implementation Date: July 3, 2017

ASP

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and payment changes for infusion drugs furnished through an item of durable medical equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

Additional information

The official instruction issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3746CP.pdf*.

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

Document history

Date of change	Description
April 7, 2017	Initial article released

MLN Matters® Number: MM10016
Related CR Release Date: April 7, 2017
Related CR Transmittal Number: R3746CP
Related Change Request (CR) Number: 10016
Effective Date: July 1, 2017
Implementation Date: July 3, 2017

Upcoming provider outreach and educational events

Medicare Speaks 2017 Miami

Date: Wednesday-Thursday, May 17-18
Time: 7:30 a.m.-4:15 p.m.
Type of Event: Face-to-face
https://medicare.fcso.com/Medicare_Speaks/0371640.asp

Medicare Part A changes and regulations

Date: Tuesday, June 13
Time: 10:00-11:30 a.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0369644.asp

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

Two easy ways to register

Online – Visit our provider training website at *http://www.fcsouniversity.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

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

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

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects® Provider eNews

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

MLN Connects® for March 23, 2017

MLN Connects® for March 23, 2017
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News & Announcements

- Connected Care: New Educational Initiative to Raise Awareness of Chronic Care Management
- Quality Payment Program: New Materials
- IRF and LTCH Compare Quarterly Refresh

Provider Compliance

- Preventive Services CMS Provider Minute Video

Upcoming Events

- 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

Medicare Learning Network® Publications & Multimedia

- Provider Enrollment Revalidation: Cycle 2 MLN Matters® Article – Revised
- Medicare-Required SNF PPS Assessments Educational Tool – Revised
- Items and Services Not Covered under Medicare Booklet – Revised

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MLN Connects® for March 30, 2017

MLN Connects® for March 30, 2017
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News & Announcements

- MIPS Annual Call for Measures and Activities through June 30
- CMS Voluntary Self-Referral Disclosure Protocol: New Form

Provider Compliance

- Billing For Stem Cell Transplants

Upcoming Events

- MIPS Cost Measure Development Listening Session – April 5
- 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
- Global Surgery: Required Data Reporting for Post-Operative Care Call – April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27

Medicare Learning Network® Publications & Multimedia

- NPI: What You Need to Know Booklet – New
- IRF-PAI Call: Video Presentation – New
- ESRD QIP Call: Follow-up Questions and Answers – New
- SNF Consolidated Billing Web-Based Training Course – Revised
- Remittance Advice Resources and FAQs Fact Sheet – Revised
- Reading a Professional Remittance Advice Booklet– Revised
- Medicare Home Health Benefit Booklet — Revised
- MLN Learning Management System – Booklet – Revised
- Medicare Enrollment for Physicians and Other Part B Suppliers Booklet – Reminder
- Medicare Enrollment for Institutional Providers Booklet – Reminder
- Safeguard Your Identity and Privacy Using PECOS Booklet – Reminder

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MLN Connects® for April 6, 2017

MLN Connects® for April 6, 2017
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News & Announcements

- Clinical Laboratory Data Reporting: Enforcement Discretion
- Open Payments Program Year 2016 Review and Dispute Period Ends May 15
- MIPS Group Web Interface and CAHPS Reporting: Registration Period Open through June 30
- Home Health and LTCH Quality Reporting Program Review and Correct Reports Available
- 2018 Medicare Shared Savings Program: Notice of Intent to Apply Guidance Document Available
- April Quarterly Provider Update Available
- Help Prevent Alcohol Misuse or Abuse

Provider Compliance

- Lumbar Spinal Fusion CMS Provider Minute Video

Claims, Pricers & Codes

- Home Health Services Pre-Claim Review Demonstration Pause

Upcoming Events

- Open Payments: Prepare to Review Reported Data Call – April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call – April 19
- Global Surgery: Required Data Reporting for Post-Operative Care Call – April 25
- Emergency Preparedness Requirements Final Rule Training Call – April 27
- Hospice Quality Reporting Program: Public Reporting Webinar – April 27

Medicare Learning Network® Publications & Multimedia

- Denial of Home Health Payments When Required Patient Assessment Is Not Received: Additional Information MLN Matters® Article – New
- SNF Value-Based Purchasing Call: Audio Recording and Transcript – New
- Dementia Care Call: Audio Recording and Transcript – New
- Reading an Institutional RA Booklet – Revised
- PECOS for Physicians and Non-Physician Practitioners Booklet – Reminder

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MLN Connects® for April 13, 2017

MLN Connects® for April 13, 2017
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News & Announcements

- Accountable Health Communities Model: CMS Selects 32 Participants
- Mapping Medicare Disparities Tool: Identify Disparities in Chronic Disease
- Questions about Medicare Enrollment Revalidation?
- Administrative Simplification: New Fact Sheet and Infographic
- National Healthcare Decisions Day is April 16

Provider Compliance

- Billing for Ambulance Transports

Claims, Pricers & Codes

- April 2017 OPPS Pricer File

Upcoming Events

- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
- Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27
- IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2

Medicare Learning Network® Publications & Multimedia

- April 2017 Catalog Available
- Quality Payment Program in 2017: Pick Your Pace Web-Based Training Course — New
- 2017 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — New
- Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 3] Educational Tool — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Educational Resources to Assist Chiropractors with Medicare Billing MLN Matters Article — Revised
- Home Health Prospective Payment System Booklet — Revised

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MLN Connects® for April 20, 2017

MLN Connects® for April 20, 2017

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News & Announcements

- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply May 1 through 31
- IRF/LTCH/SNF QRP Data Due May 15
- Rural Community Hospital Demonstration: Submit Applications by May 17
- New Quality Payment Program Resources Available
- Revised CMS-588: Electronic Funds Transfer Authorization Agreement
- SNF QRP Quick Reference Guide Now Available
- Beneficiary Notice Initiative: New Email Address for Questions
- April is National Minority Health Month

Provider Compliance

- Psychiatry and Psychotherapy CMS Provider Minute Video

Upcoming Events

- Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27
- IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2

Medicare Learning Network® Publications & Multimedia

- Medicare Shared Savings Program Call: Audio Recording and Transcript — New
- Provider Compliance Products Fact Sheet — Revised
- Provider Compliance Tips for Spinal Orthoses Fact Sheet — Revised
- SNF Billing Reference Booklet — Revised

CMS MLN Connects Provider eNews – special edition

Wednesday, April 14, 2017
CMS proposes 2018 payment and policy updates for Medicare hospital admissions, releases a request for information

Proposed rule seeks transparency, flexibility, program simplification and innovation to transform the Medicare program

On April 14, CMS issued a *proposed rule* that would update 2018 Medicare payment and polices when patients are admitted into hospitals. The proposed rule aims to relieve regulatory burdens for providers; supports the patient-doctor relationship in health care; and promotes transparency, flexibility, and innovation in the delivery of care.

"Through this proposed rule we want to reduce burdens for hospitals so they can focus on providing high quality care for patients," said CMS Administrator Seema Verma. "Medicare is better able to support the work of dedicated hospitals and clinicians who provide the care that people need with these more flexible and simplified approaches."

CMS is committed to transforming the health care delivery system – and the Medicare program – by putting a strong focus on patient-centered care, so providers can direct their time and resources to patients and improve outcomes. In addition to the payment and policy proposals, CMS is releasing a Request for Information to solicit ideas for regulatory, policy, practice and procedural changes to better achieve transparency, flexibility, program simplification and innovation. This will inform the discussion on future regulatory action related to inpatient and long-term hospitals.

In relieving providers of administrative burdens and encouraging patient choice, CMS is proposing:

- a one year regulatory moratorium on the payment policy threshold for patient admissions in long-term care hospitals while CMS continues to evaluate long-term care hospital policies
- to reduce clinical quality measure reporting requirements for hospitals that have implemented electronic health records

Due to the combination of proposed payment rate increases and other proposed policies and payment adjustments, CMS projects that hospitals would see a total increase in inpatient operating prospective payments of 2.9 percent in fiscal year 2018. CMS also projects that, based on the changes included in the proposed rule, payments to long-term care hospitals would decrease by approximately 3.75 percent in fiscal year 2018.

For more information:

- Full text of this excerpted *CMS press release* (issued April 14)
- *CMS fact sheet*

CMS MLN Connects Provider eNews – special edition

Wednesday, April 5, 2017
Home health services pre-claim review demonstration pause

As of April 1, 2017, the pre-claim review demonstration for home health services is paused in Illinois and didn't expand to Florida. We will process claims under normal processing rules. The Centers for Medicare & Medicaid Services will notify providers at least 30 days in advance of further developments related to the demonstration. For more information, see the *Pre-Claim Review Demonstration* web page and *FAQs*.

First Coast Service Options Phone Numbers

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

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

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

Interactive Voice Response
877-602-8816

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

Overpayments
904-791-8123

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

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

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

Puerto Rico

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Redetermination (cont'd)

U.S. Virgin Islands:

First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Puerto Rico

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

Special delivery/courier services

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

Other Medicare carriers and intermediaries

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

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

Railroad Medicare

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

Regional home health/hospice intermediary

Palmetto GBA
Medicare Part A
34650 US HWY 19N
Palm Harbor, FL 34684

Contact CMS

Centers for Medicare & Medicaid Services (CMS)
(https://www.cms.gov/)

Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations

ROATLFM@CMS.HHS.GOV

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

Beneficiary customer service

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

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