Medicare A Connection
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
May 2017

In this issue

Qualified Medicare beneficiary indicator in the Medicare fee-for-service claim processing system

Provider types affected

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

Provider action needed

Change request (CR) 9911 modifies the Medicare claim processing systems to help providers more readily identify the qualified Medicare beneficiary (QMB) status of each patient and to support providers' ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare's claim processing systems. This system enhancement will trigger notifications to providers (through the provider remittance advice) and to beneficiaries (through the Medicare summary notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Under federal law, Medicare providers may not bill individuals enrolled in the QMB program for Medicare deductibles, coinsurance, or copayments, under any circumstances. (See Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.) State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances. Nonetheless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing

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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 Issues

Part A processing issues from IOCE errors for OPPS claims

Issue

First Coast has become aware of issues with outpatient prospective payment system (OPPS) services due to integrated outpatient code editor (IOCE) logic errors.

Resolution

This problem has been resolved with IOCE logic corrections in the April 2017 quarterly release.

Status/date resolved

Open. IOCE corrections implemented April 1, 2017.

Provider action

Resubmit claims for the situations and qualifications listed below.

- Comprehensive ambulatory payment classification (C-APC) – For this logic error, outlier payments were not calculated when they should have been.
- Type of bill (TOB) 13x
- Dates of service (DOS) January 1, 2015, through April 1, 2017
- Claims processed January 1, 2017, through April 1, 2017
- Status indictor (IOCE flag 1) = J1
- Outlier payment was expected but not received due to composite service identified on same claim

Conditional APC – For this logic error, the IOCE conditional APC program logic was inadvertently turned off when the packaging logic changed from a "date of service" to a "claim" level application and is causing all lines with a status indicator of "Q1", "Q2", and "Q3" to package in error.

- TOB 13x
- Claims received January 1, 2017, through April 1, 2017

- No reimbursement on claim
- All lines contained edit W7047
- **For observation and new technology APC services billed with PN modifier** – For this logic error, observation and new technology APC services billed with the PN modifier were hitting the W7101 edit.
- TOB 13x
- DOS from January 1, 2017, through April 1, 2017
- Claims processed January 1, 2017, through April 1, 2017
- Observation lines that contained modifier PN that hit edit W7101

Current processing issues

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

Find out first: Subscribe to First Coast *eNews*

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General Information

QMB

front page

from the beneficiary) as payment in full for services rendered to an individual enrolled in the QMB program.

CR 9911 aims to support Medicare providers' ability to meet these requirements by modifying the Medicare claim processing system to clearly identify the QMB status of all Medicare patients. Currently, neither the Medicare eligibility systems (the HIPAA eligibility transaction system (HETS)), nor the claim processing systems (the FFS shared systems), notify providers about their patient's QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare summary notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

CR 9911 includes modifications to the FFS claim processing systems and the *Medicare Claims Processing Manual* to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare's common working file (CWF) will obtain QMB indicators so the claim processing systems will have access to this information.

- CWF will provide the claims processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims; and outpatient institutional types of bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x); home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x, or 060x; and skilled nursing facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).
- CWF will provide the claim processing systems the QMB indicator if the "through date" falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the remittance advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with three new remittance advice remark codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

- N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

In addition, the MACs will include a claim adjustment reason code of 209 ("Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with group code OA (other adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional information

The official instruction, CR 9911, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3764CP.pdf*.

For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the *MLN Matters*® article, SE1128, at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.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

- **February 3, 2017** - Initial article released.
- **May 1, 2017** - The article was revised to reflect a revised CR 9911 issued April 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. All other information remains the same.

MLN Matters® Number: MM9911 *Revised*
Related Change Request (CR) #: CR 9911
Effective Date: For claims processed on or after October 2, 2017
Related CR Release Date: April 28, 2017
Related CR Transmittal #: R3764CP
Implementation Date: October 2, 2017

Prohibition on billing dually eligible individuals enrolled in the QMB program

***Note**: This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the qualified Medicare beneficiary (QMB) program. All other information is the same. This information was previously published in the October 2011 Medicare A Connection, pages 8-10.*

Provider types affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in original Medicare or a Medicare advantage (MA) plan.

What you need to know

Stop – impact to you

This special edition *MLN Matters*® article from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing**. QMB is a Medicare savings program (MSP) that exempts Medicare beneficiaries from Medicare cost-sharing liability.

Caution – what you need to know

The QMB program is a state Medicaid benefit that covers Medicare premiums and deductibles, coinsurance, and copayments, subject to state payment limits. States may limit their liability to providers for Medicare deductibles, coinsurance, and copayments under certain circumstances. Medicare providers may not bill QMB individuals for Medicare cost-sharing, regardless of whether the state reimburses providers for the full

Medicare cost-sharing amounts. Further, all original Medicare and MA providers--not only those that accept Medicaid--must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately bill QMB individuals are subject to sanctions.

Go – what you need to do

Refer to the *Background* and *Additional information* sections of this article for further details and resources about this guidance. Please ensure that you and your staff are aware of the federal billing law and policies regarding QMB individuals. Contact the Medicaid agency in the states in which you practice to learn about ways to identify QMB patients in your state and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a MA provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments.

Billing of QMBs is prohibited by federal law

Federal law bars Medicare providers from billing a QMB beneficiary under any circumstances. See *Section 1902(n)(3)(B) of the Social Security Act* **(the Act), as modified by Section 4714 of the Balanced Budget Act of 1997**. QMB is a Medicaid program for Medicare beneficiaries that exempt them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who do not follow these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

Inappropriate billing of QMB individuals persists

Despite federal law, improper billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to *Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015*.

Important clarifications concerning the QMB billing law

Be aware of the following policy clarifications to ensure compliance with QMB billing requirements.

1. All original Medicare and MA providers--not only those that accept Medicaid--must abide by the billing prohibitions.

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1. QMB individuals retain their protection from billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different state than the state in which care is rendered.
2. Note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the state Medicaid manual, which is no longer in effect.

Ways to improve processes related to QMBs

Proactive steps to identify QMB individuals you serve and to communicate with state Medicaid agencies (and MA plans if applicable), can promote compliance with QMB billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients, such as finding out the cards that are issued to QMB individuals, so you can in turn ask all your patients if they have them. Learn if you can query state systems to verify QMB enrollment among your patients. MA providers should contact the plan to determine how to identify the plan's QMB enrollees. Beginning October 1, 2017, you will be able to readily identify the QMB status of your patients with new Medicare fee-for-services improvements. Refer to *Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System* for more information about these improvements.
2. Determine the billing processes that apply to seeking reimbursement for Medicare cost-sharing from the states in which you operate. Different processes may apply to original Medicare and MA services provided to QMB beneficiaries. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare benefits coordination & recovery center (BCRC) to automatically receive Medicare-adjudicated claims.
   - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare remittance advice.
   - Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your state. You may need to complete a state provider registration process and be entered into the state payment system to bill the state.
3. Ensure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

QMB eligibility and bene its (see page 7)

* States can effectively raise these Federal income and resources criteria under Section *1902(r)(2)* of the Act.

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a "conditional basis"). For more information on this process, refer to Section HI 00801.140 of the *Social Security Administration Program Operations Manual System*.

Additional information

For more information about dual eligibles under Medicare and Medicaid, please visit *https://www.medicaid.gov/affordable-care-act/dual-eligibles/index.html* and *https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html* and refer to Dual Eligible Beneficiaries Under Medicare and Medicaid. For general Medicaid information, please visit *http://www.medicaid.gov/index.html*.

Document history

Date of change	Description
May 12, 2017	This article was revised May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.
January 12, 2017	This article was revised to add a reference to *MLN Matters*® article MM9817, which instructs Medicare administrative contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.
February 4, 2016	The article was revised February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 of "Important Clarifications Concerning QMB Balance Billing Law."
February 1, 2016	The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table.

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Date of change	Description
March 28, 2014	The article was revised to change the name of the coordination of benefits contractor (COBC) to BCRC.

MLN Matters® Number: SE1128 *Revised*
Related Change Request (CR) #: N/A

Release Date of Revised Article: May 12, 2017
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

MB eligibility and benefits

Program	Income criteria*	Resources criteria*	Medicare Part A and Part B enrollment	Other criteria	Benefits
QMB only	≤100% of federal poverty line (FPL)	≤3 times SSI resource limit, adjusted annually in accordance with increases in consumer price index	Part A***	Not applicable	▪ Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid state plan (even if payment is not available under the state plan for these charges, QMBs are not liable for them)
QMB plus	≤100% of FPL	Determined by state	Part A***	Meets financial and other criteria for full Medicaid benefits	▪ Full Medicaid coverage ▪ Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid state plan (even if payment is not available under the state plan for these charges, QMBs are not liable for them)

* States can effectively raise these federal income and resources criteria under Section *1902(r)(2)* of the Act.

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a "conditional basis"). For more information on this process, refer to Section HI 00801.140 of the *Social Security Administration Program Operations Manual System*.

Updated manual guidelines for EFT payments and change of ownership

Provider type affected

This *MLN Matters*® article is intended for providers involved in a change of ownership (CHOW) submitting claims to Part A & B Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Special edition article SE17012 clarifies language in Chapter 15, Section 15.7.7.1.5 of the *Medicare Program Integrity Manual* related to electronic funds transfer (EFT) payments and changes of ownership (CHOWs). Please make sure your staffs are aware of this update.

Background

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 9953 (effective May 15, 2017), for the purpose of making revisions to Chapter 15, Section 15.7.7.1.5 (Electric Funds Transfer (EFT) Payments and CHOWs) of the *Medicare Program Integrity Manual*. The revisions explain that after a CHOW has been processed, only the buyer is permitted to submit claims.

CHOW is defined in 42 CFR 489.18 (a) and generally means, in the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law. In the case of a corporation, the term generally means the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

The most common example of a CHOW occurs when a provider's CMS certification number (CCN) and provider agreement is transferred to another entity as a result of the latter's purchase of the provider. To illustrate, suppose entity A is enrolled in Medicare, but entity B is not. B acquires A. Assuming all regulatory requirements are met, A's provider agreement and CCN number will transfer to B.

Upon accepting the provider agreement, the new owner accepts the terms and conditions under which it was originally issued. Once the CHOW processes and the MAC: 1) receives the tie-in notice from the CMS regional office; and 2) updates the Provider Enrollment Chain and Ownership System (PECOS), claims will only be paid under the new owner's tax identification number, national provider identifier and CCN, or provider transaction number.

MACs will no longer have the ability to update the crosswalk in order for the Seller to complete their billing. Therefore, the old and new owners are responsible for working together on payment arrangements for claims for services furnished during and before the CHOW is processed.

The updated manual language follows:

PIM language update

In a CHOW, the existing provider agreement is automatically assigned to the buyer/transferee. If the buyer/transferee does not explicitly reject automatic assignment before the transfer date, the provider agreement is automatically assigned, along with the CCN, effective on the transfer date. The assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. Among other things, this means that the contractor will continue to adjust payments to the provider to account for prior overpayments and underpayments, even if they relate to services provided before the sale/transfer. If the buyer rejects assignment of the provider agreement, the buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will never pay the applicant for services the prospective provides before the date on which the provider qualifies for Medicare participation as an initial applicant.

Depending on the terms of the sale, the buyer/transferee may obtain a new NPI or maintain the existing NPI. After CHOW processing is complete, the seller/transferor will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the buyer is permitted to submit claims using the existing CCN. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.

Additional information

The official instruction, CR 9953, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R715PI.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
May 16, 2017	Initial article released.

MLN Matters® Number: SE17012
Related Change Request (CR) Number: 9953
Article Release Date: May 16, 2017
Effective Date: May 15, 2017
Related CR Transmittal Number: R715PI
Implementation Date: May 15, 2017

New physician specialty code for advanced heart failure and transplant cardiology, medical toxicology, and hematopoietic cell transplantation and cellular therapy

Provider types affected

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

Provider action needed

Change request (CR) 9957 establishes new physician specialty codes for advanced heart failure and transplant cardiology (C7), medical toxicology (C8), and hematopoietic cell transplantation and cellular therapy (C9). The new codes are effective on October 1, 2017. Make sure that your billing staffs are aware of these new specialty codes.

Background

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Medicare physician specialty codes describe the specific/unique types of medicine that physicians (and certain other suppliers) practice. The Centers for Medicare & Medicaid Services (CMS) uses specialty codes for programmatic and claim processing purposes.

The CMS-855I and CMS-855O paper applications will be updated to reflect the new specialties in the future. In the interim, providers shall select the 'Undefined physician type' option on the enrollment application and specify the applicable specialty in the space provided.

Existing enrolled providers who want to update their specialty to reflect one of the new specialties must submit a change of information application to their MAC. Providers may submit an enrollment application to initially enroll or update their specialty within 60 days of the implementation date of the new specialties.

Additional information

The official instruction, CR 9957, consists of two transmittals and updates two Medicare manuals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3762CP.pdf*. The second transmittal updates the Medicare Financial Management Manual and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R283FM.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: MM9957
Related Change Request (CR) #: CR 9957
Related CR Release Date: April 28, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R283FM and R3762CP
Implementation Date: October 2, 2017

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CMS guidelines for prior authorization

***Note**: This article was revised May 1, 2017, to include a new web address for the required prior authorization list. All other information remains the same. This information was previously published in the February 2017 Medicare A Connection, pages 4-5.*

Provider types affected

This *MLN Matters*® article is intended for providers ordering certain DMEPOS items and suppliers submitting claims to Medicare administrative contractors (MACs) for items furnished to Medicare beneficiaries.

What you need to know

Change request (CR) 9940 updates the Centers for Medicare & Medicaid Services (CMS) *Program Integrity Manual* to permit the MACs to conduct prior authorization processes, as so directed by CMS through individualized operational instructions. As of January 2017,

prior authorization of certain durable medical equipment, prosthetic, orthotic, and supply items, frequently subject to unnecessary utilization, is the only permanent (non-demonstration) prior authorization program approved for implementation. Make sure your billing staff is aware of these changes.

Background

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted to a medical review contractor for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing. It is a process that permits the submitter/requester (for example, provider, supplier, beneficiary) to send in medical documentation, in advance of the item or service being rendered, and subsequently billed, in order to verify its eligibility for Medicare claim payment.

For any item or service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category
- Be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare coverage, coding and payment requirements

Contractors shall, at the direction of CMS or other authorizing entity, conduct prior authorizations and alert the requester/submitter of any potential issues with the information submitted.

A prior authorization request decision can be either a provisional affirmative or a non-affirmative decision.

- A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare's coverage, coding, and payment requirements.
- A non-affirmative decision is a finding that the submitted information/ documentation does not meet Medicare's coverage, coding, and payment requirements, and if a claim associated with the prior authorization is submitted for payment, it would not be paid. MACs shall provide notification of the reason for the non-affirmation, if a request is non-affirmative, to the submitter/requester. If a prior authorization request receives a non-affirmative decision, the prior authorization request can be resubmitted an unlimited number of times.
- Prior authorization may also be a condition of payment. This means that claims submitted without an indication that the submitter/requester received a prior authorization decision (that is, unique tracking number (UTN)) will be denied payment.

Each prior authorization program will have an associated operational guide that will be available on the CMS website. In addition, MACs will educate stakeholders each time a new prior authorization program is launched. That education will include the requisite information and timeframes for prior authorization submissions and the vehicle to be used to submit such information to the MAC.

Prior authorization program for DME MACs

A prior authorization program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items that are frequently subject to unnecessary utilization is described in 42 CFR 414.234. Among other things, this section establishes a master list of certain DMEPOS items meeting inclusion criteria and potentially subject to prior authorization. CMS will select Healthcare Common Procedure Coding System (HCPCS) codes from the prior authorization master list to be placed on the required prior authorization list, and such codes will be subject to prior authorization as a condition of payment. In selecting HCPCS codes, CMS may consider factors such as geographic location, item utilization or cost, system capabilities, administrative burden, emerging trends, vulnerabilities identified in official agency reports, or other data analysis.

- The prior authorization master list is the list of DMEPOS items that have been identified using the inclusion criteria described in 42 CFR 414.234.
- The list of required DMEPOS prior authorization items contains those items selected from the prior authorization master list to be implemented in the prior authorization program. The list of required DMEPOS prior authorization items will be updated as additional codes are selected for prior authorization.
- CMS may suspend prior authorization requirements generally or for a particular item or items at any time and without undertaking rulemaking. CMS provides notification of the suspension of the prior authorization requirements via *Federal Register* notice and posting on the CMS prior authorization website.

The items on the required prior authorization list, a "CMS Final Rule 6050-F" subpage containing the master list, as well as other pertinent information and supporting documents regarding this program, are available at

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Issue identified with certain remittance advices

First Coast Service Options, Inc. (First Coast) has identified an issue with remittance advices that were issued for claims processed January 1, 2017, through February 9, 2017. Specifically, remittance advices for claims processed from January 1, 2017, through February 9, 2017, that met all of the criteria below displayed the incorrect payment reduction amounts.

- When the Physician Quality Reporting System (PQRS), Electronic Health Records (EHR), and/or ambulatory surgical center (ASC) quality reporting payment reductions were applied and the service had a quantity billed greater than one and the procedure code has a multiple procedure payment reduction (MPPR) indicator other than one.

Note: The MPPR indicator can be located using the fee schedule lookup tool. The fee schedule lookup tool – help guide can assist in utilizing the lookup tool and locating the MPPR indicator.

Although the impacted remittances are showing a higher

amount for the reductions than what was truly taken on the claims, the actual payment amount is correct. This issue was caused by a recent update to Medicare's internal processing system and was corrected February 10, 2017. First Coast will not adjust the impacted claims to produce corrected remittances, but wants to assure you that the correct payments have been issued for these claims.

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https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html.

Additional information

The official instruction, CR 9940, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R698PI.pdf*.

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

Document history

- January 20, 2017 - Initial article released.
- May 1, 2017 - Article revised to include new web address for the required prior authorization list. All other information remains the same.

MLN Matters® Number: MM9940 *Revised*
Related Change Request (CR) #: CR 9940
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This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

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

Effective and notice dates

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

Electronic notification

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

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Before you file an appeal...

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

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

Retired LCD

Implantable miniature telescope (IMT) – retired Part A and Part B LCD

LCD ID number: L33377 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the implantable miniature telescope (IMT) local coverage determination (LCD), it was determined that this LCD is no longer required and, therefore, is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after May 10, 2017**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Multiple Part A and Part B local coverage determinations being retired

LCD ID number: L33987, L34000, L33708, L33596, L34020 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on data analysis review of the following local coverage determinations (LCDs), it was determined that these LCDs are no longer required and, therefore, are being retired.

L33987 – Computerized Dynamic Posturography

L34000 – Ganciclovir and Cidofovir

L33708 – Plerixafor (Mozobil®)

L33596 – Qutenza (capsaicin) 8% patch

L34020 – Sargramostim (GM-CSF, Leukine®)

Effective date

The retirement of these LCDs is effective for services rendered **on or after May 10, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Revisions to LCD

Gemcitabine (Gemzar®) – revision to the Part A and Part B LCD

LCD ID number: L33726 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for gemcitabine (Gemzar®) was revised to add the indication "cancers of the nasopharynx" to the "Off label indications" section of the LCD. Also, the ICD-10-CM codes C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C14.0, C14.2, C30.0, D37.05, Z85.21, Z85.22, Z85.810, Z85.818, and Z85.819 were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) code J9201. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after May 16, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Clarifying medical review of hospital claims for Part A payment

Provider type affected

This *MLN Matters*® article is intended for providers that submit institutional claims to Medicare administrative contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10080 clarifies the medical review requirements for Part A payment of short stay hospital claims (more commonly referred to as the "two-midnight" rule) for MACs, supplemental medical review contractors (SMRC), recovery audit contractors and the comprehensive error rate testing (CERT) contractors. (Note, such reviews are currently, mainly overseen by quality improvement organizations). Make sure that your staffs are aware of these policies.

Background

CR 10080 updates the *Medicare Program Integrity Manual (PIM)*, Chapter 6, Section 6.5.2, to ensure consistency with recent regulations, as published by the Centers for Medicare & Medicaid Services (CMS). It clarifies the medical review requirements for Part A payment of short stay hospital claims (more commonly referred to as the "two-midnight" rule) status.

For purposes of determining the appropriateness of Medicare Part A payment, Medicare contractors will conduct reviews of medical records for inpatient acute hospital inpatient prospective payment system (PPS) hospital, critical access hospital (CAH), inpatient psychiatric facility (IPF) and long term care hospital (LTCH) claims, as appropriate and as permitted by CMS, based on data analysis and their prioritized medical review strategies. Review of the medical record must indicate that hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay, and that the stay was appropriate for Medicare Part A payment.

These updates apply to MACs, as well as Medicare's SMRC, recovery audit contractors, and the CERT contractor. The following describes the updates:

A. Determining the appropriateness of Part A payment

The term "patient status review" refers to reviews conducted by Medicare contractors to determine a hospital's compliance with Medicare requirements to bill for Medicare Part A payment. "Patient status reviews" may result in determinations that claims are not properly payable under Medicare Part A. "Patient status reviews" do not involve changing a beneficiary's status from inpatient to outpatient.

Medicare contractors will conduct such reviews in accordance with two distinct, but related medical review policies:

1. A **two-midnight presumption** which helps guide contractor selection of claims for medical review

Per the two-midnight presumption, Medicare contractors will presume hospital stays spanning two or more midnights after the beneficiary is formally admitted as an inpatient are reasonable and necessary for Part A payment. Generally, Medicare contractors will not focus their medical review efforts on stays spanning two or more midnights after formal inpatient admission absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the two-midnight presumption. (Due to its function, the CERT contractor would not exclude such claims from its review and calculation of the improper payment rate).

2. A **two-midnight benchmark** which helps guide contractor reviews of short stay hospital claims for Part A payment

Per the two-midnight benchmark, hospital stays are generally payable under Part A if the admitting practitioner expects the beneficiary to require medically necessary hospital care spanning two or more midnights and such reasonable expectation is supported by the medical record documentation. Medicare Part A payment is generally not appropriate for hospital stays expected to span less than two midnights.

If a stay is not reasonably expected to span two or more midnights, Medicare contractors will assess the claim to determine if an exception exists that would nonetheless make Part A payment appropriate, including:

1. If the procedure is on the secretary's list of "inpatient only" procedures (identified through annual regulation)
2. If the procedure is a CMS-identified, national exception to the two-midnight benchmark
3. If the admission otherwise qualifies for a case-by-case exception to the two-midnight benchmark because the medical record documentation supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a Two-Midnight expectation. Medicare contractors will note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the two-midnight benchmark.

Hospital treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The two-midnight rule does not prevent such practitioners from providing any service at any hospital, regardless of the expected duration of the service. Rather, it provides a benchmark to help guide consistent Part A payment decisions.

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Reviewing hospital claims for patient status: The two-midnight benchmark determines if the stay involved an "inpatient-only" procedure

When conducting patient status reviews, assuming all other coverage requirements are met, the Medicare review contractor will determine Medicare Part A payment to be appropriate if a medically necessary procedure classified by the secretary as an "inpatient-only" procedure is performed. "inpatient-only" procedures are so designated per 42 C.F.R. Section 419.22(n), and are detailed in the annual outpatient prospective payment system (OPPS) regulation.

MACs will review the medical documentation and make an initial determination of whether a medically necessary inpatient only procedure is documented within the medical record. If so, and if the other requisite elements for payment are present, then the Medicare review contractor will deem Medicare Part A payment to be appropriate, without regard to the expected or actual length of stay.

If the Medicare review contractor does not identify an inpatient only procedure during the initial review, the claim should be assessed in accordance with the two-midnight benchmark.

Calculating time relative to the two-midnight benchmark

Per the two-midnight benchmark, Medicare contractors will assess short stay (that is, less than TWO midnights after formal inpatient admission) hospital claims for their appropriateness for Part A payment. Generally, hospital claims are payable under Part A if the contractor identifies information in the medical record supporting a reasonable expectation on the part of the admitting practitioner at the time of admission that the beneficiary would require a hospital stay that crossed at least two midnights.

Medicare review contractor reviews will assess the information available at the time of the original physician/practitioners' decision as follows:

1. The expectation for sufficient documentation is well rooted in good medical practice. Physician/practitioners need not include a separate attestation of the expected length of stay; rather, this information may be inferred from the physician/practitioner's standard medical documentation, such as his/her plan of care, treatment orders, and progress notes.
2. Medicare contractors will consider the complex medical factors that support both the decision to keep the beneficiary at the hospital and the expected length of the stay. These complex medical factors may include, but are not limited to, the beneficiary's medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered.
3. For purposes of determining whether the admitting practitioner had a reasonable expectation of hospital care spanning two or more midnights at the time of admission, the Medicare contractors will take into account the time the beneficiary spent receiving contiguous outpatient services within the hospital prior to inpatient admission.
   a) This pre-admission time may include services such as observation services, treatments in the emergency department (ED), and procedures provided in the operating room or other treatment area.
   b) If the beneficiary was transferred from one hospital to another, then for the purpose of determining whether the beneficiary satisfies the two-midnight benchmark at the recipient hospital, the Medicare contractors will take into account the time and treatment provided to the beneficiary at the initial hospital. In the event that a beneficiary was transferred from one hospital to another, the Medicare review contractor may request documentation that was authored by the transferring hospital to support the medical necessity of the services provided and to verify when the beneficiary began receiving hospital care. Medicare contractors will generally expect this information to be provided by the recipient hospital seeking Part A payment.
   c) Medicare contractors will continue to follow CMS' longstanding instruction that Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary. Therefore, Medicare contractors will exclude extensive delays in the provision of medically necessary care from the Two-Midnight benchmark calculation. Factors that may result in an inconvenience to a beneficiary, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission. When such factors affect the beneficiary's health, Medicare contractors will consider them in determining whether Part A payment is appropriate for an inpatient admission.

Note: While, as discussed above, the time a beneficiary spent as an outpatient before being admitted as an inpatient is considered during the medical review process for purposes of determining the appropriateness of Part A payment, such time does not qualify as inpatient time. (See the *Medicare Benefit Policy Manual*, *Chapter 1*, Section 10 for additional information regarding the formal order for inpatient admission.)

Unforeseen Circumstances Interrupting Reasonable Expectation

The two-midnight benchmark is based on the expectation at the time of admission that medically necessary hospital care will span two or more midnights. Medicare contractors will, during the course of their review, assess the reasonableness of such expectations. In the event that a stay does not span two or more midnights, Medicare

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contractors will look to see if there was an intervening event that nonetheless supports the reasonableness of the physician/practitioner's original judgment.

An event that interrupts an otherwise reasonable expectation that a beneficiary's stay will span two or more midnights is commonly referred to by CMS and its contractors as an unforeseen circumstance. Such events must be documented in the medical record, and may include, but are not limited to, unexpected death, transfer to another hospital, departure against medical advice, clinical improvement, and election of hospice in lieu of continued treatment in the hospital.

Stays expected to span less than two midnights

When a beneficiary enters a hospital for a surgical procedure not specified by Medicare as inpatient only under 42 C.F.R. Section 419.22(n), a diagnostic test, or any other treatment, and the physician expects to keep the beneficiary in the hospital for less than two midnights, the services are generally inappropriate for inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the beneficiary used a bed.

The Medicare review contractor will assess such claims to see if they qualify for a general or case-by-case exception to this generalized instruction, which would make the claim appropriate for Medicare Part A payment, assuming all other requirements are met.

Exceptions to the two-midnight rule:

1. Medicare's inpatient-only list

Inpatient admissions where a medically necessary Inpatient-Only procedure is performed are generally appropriate for part A payment regardless of expected or actual length of stay.

2. Nationally-identified tare & unusual exceptions to the two-midnight rule

If a general exception to the two-midnight benchmark, as identified by CMS, is present within the medical record, the Medicare review contractor will consider the inpatient admission to be appropriate for Part A payment so long as other requirements for Part A payment are met. CMS has identified the following national or general exception to the two-midnight rule:

a) Mechanical ventilation initiated during present visit:

CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than two midnights, and to embody the same characteristics as those procedures included in Medicare's inpatient–only list. While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require two or more midnights of hospital care, if the physician expects that the beneficiary will only require one midnight of hospital care, but still orders inpatient admission, Part A payment is nonetheless generally appropriate.

3. Physician-identified case-by-case exceptions to the two-midnight rule

For hospital stays that are expected to span less than two midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the medical record supports the admitting physician/practitioner's judgment that the beneficiary required hospital care on an inpatient basis despite the lack of a two-midnight expectation. Medicare contractors will consider, when assessing the physician's decision, complex medical factors including but not limited to:

- The beneficiary history and comorbidities
- The severity of signs and symptoms
- Current medical needs
- The risk of an adverse event

Medicare contractors will note CMS' expectation that stays under 24 hours would rarely qualify for an exception to the two-midnight benchmark and as such, may be prioritized for medical review.

Additional information

The official instruction, CR 10080, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R716PI.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/*.

The *CMS Fact Sheet: Two-Midnight Rule* is available at *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-01-2.html*.

Document history

Date of change	Description
May 15, 2017	Initial article released

MLN Matters® Number: MM10080
Related CR Release Date: May 12, 2017
Related CR Transmittal Number: R716PI
Related Change Request (CR) # 10080
Effective Date: June 13, 2017
Implementation Date: June 13, 2017

Remittance advice messaging for the 20-hour weekly minimum for PHP services

Provider types affected

This *MLN Matters*® article is intended for outpatient prospective payment system (OPPS) providers submitting partial hospitalization program (PHP) claims to Medicare administrative contractors (MACs) for PHP services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9880 implements informational messaging, effective October 1, 2017, that conveys supplemental and educational information to the provider submitting claims for PHP services where the patient did not receive the minimum 20 hours per week of therapeutic services his plan of care indicates is required, on claims with line item date of service (LIDOS) on or after October 1, 2017. When the minimum 20 hours per week care is not provided, MACs will return remittance advice remarks code N787 - "Alert: An eligible PHP beneficiary requires a minimum of 20 hours of PHP services per week, as evidenced in the plan of care. PHP services must be furnished in accordance with the plan of care."

Background

Partial hospitalization services are intensive outpatient services provided in lieu of inpatient hospitalization for mental health conditions. The regulation at 42 CFR 410.43(c)(1) states that PHPs are intended for patients who require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care. Additionally, the regulation at 42 CFR 410.43(a)(3) requires that PHP services are services that are furnished in accordance with a physician certification and plan of care as specified under 42 CFR 424.24(e).

Additional information

The official instruction, CR 9880, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1833OTN.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
April 28, 2017	Initial article released.

MLN Matters® Number: MM9880
Related Change Request (CR) #: CR 9880
Related CR Release Date: April 28, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1833OTN
Implementation Date: October 2, 2017

Widespread probe results for MS DRG 885 and prepayment review

First Coast Service Options Inc. (First Coast) conducted two widespread probes (WSPs) in response to comprehensive error rate testing (CERT) errors and 30-day readmission data trending higher than national comparison data. WSPs were for diagnosis-related group (MS DRG) 885 (Psychoses with readmissions within 30 days and admissions that exceed four days or more).

Overall widespread probe findings for MS DRG 885 Psychoses

- Overall error rate 63.62 percent
  - 20 providers probed with error rates ranging from 0-100 percent
  - 16 providers had denials for documentation requirements not met according to Medicare guidelines
  - Four providers had zero percent error rates

Overall widespread probe findings for MS DRG 885 with 30-day readmit

- Overall error rate 40.85 percent
  - 20 providers probed with error rates ranging from 1-100 percent
  - Two providers with 100 percent error rates did not submit documentation
  - Seven providers had denials for either documentation requirements not met according to Medicare guidelines or for medical necessity
  - 11 providers had zero percent error rates

As a follow up action due to the high error rates First Coast has determined to place MS DRG 885 inpatient stays of three+ days on prepayment review.

The Centers for Medicare & Medicaid Services (CMS) internet-only manual (IOM) guidelines *Medicare Benefit Policy Manual, Chapter 2 – Inpatient Psychiatric Hospital Services* will provide specific regulations to comply with medical necessity and documentation requirements.

First Coast will implement prepay threshold for review of MS DRG 885 will be applied to claims processed on or after May 3, 2017.

All three patient reason for visit fields to be included in FISS editing

Provider types affected

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

What you need to know

Change request (CR) 9672 informs MACs about changes that update logic in the fiscal intermediary standard system (FISS) (Medicare's system for processing institutional claims) to allow editing of the expanded "Patient Reason for Visit (PRV)" fields. CR 9672 requires updating of FISS to ensure that all of the national coverage determination (NCD) edits within reason code ranges 3xxxx and 59xxx that are tied to the diagnosis code fields include all three PRV fields for outpatient hospital claims on types of bill (TOB) 013x and 085x. CR 9672 makes no policy changes.

Additional information

The official instruction, CR 9672, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1852OTN.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

- May 5, 2017 – Initial article released.
- May 18, 2017 – The article is revised to reflect the revised CR 9672 issued May 17. The article is revised to change the effective and implementation dates, the CR release date, transmittal number, and the Web address for accessing the CR. All other information remains the same.

MLN Matters® Number: MM9672
Related Change Request (CR) #: CR 9672
Related CR Release Date: May 17, 2017
Effective Date: Claims received on or after October 1, 2017
Related CR Transmittal #: R1852OTN
Implementation Date: October 2, 2017

Admitting diagnosis code field to be included in FISS editing

Provider types affected

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

Provider action needed

Change request (CR) 9753 informs MACs about changes to system edits by the maintainer of Medicare's fiscal intermediary shared system (FISS). Make sure that your billing staffs are aware of these changes.

Background

In prior system updates, Medicare required FISS to review diagnosis fields. CR 9753 updates various system edits to look at the admitting diagnosis field. FISS editing is now being updated to ensure that all of the national coverage determination (NCD) edits within reason code ranges 3xxxx and 59xxx that are tied to the diagnosis code fields (other than the primary diagnosis field) include the admitting diagnosis field for Inpatient claims on types of bill (TOB) 011x, 012x, 018x, 021x, and 022x.

Additional information

The official instruction, CR 9753, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1832OTN.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: MM9753
Related Change Request (CR) #: CR 9753
Related CR Release Date: April 28, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1832OTN
Implementation Date: October 2, 2017

Office of Inspector General Report: Stem cell transplantation

***Note**: This article was revised on May 1, 2017, to make a number of clarifications and to delete the table that had been in the article. This information was previously published in the December 2016 Medicare A Connection, pages 57-59.*

Provider types affected

This article is intended for providers billing Medicare administrative contractors (MACs) for services related to stem cell transplantation.

Provider action needed

The Office of the Inspector General (OIG) recently completed a review of Medicare claims related to stem cell transplants. This article is intended to address issues of incorrect billing as a result of the *February 2016 OIG report* and to clarify coverage of stem cell transplantation. This article does not introduce any new policies. It is intended to clarify the billing for stem cell services.

Background

The Centers for Medicare & Medicaid Services (CMS) has a coverage policy for stem cell transplantation, and the *Medicare National Coverage Determination (NCD) Manual* (*Publication 100-03, Section 110.8*) states that stem cell transplantation is a process in which stem cells are harvested from either a patient's or donor's bone marrow or peripheral blood for intravenous infusion.

Types of stem cell transplants that are covered:

Medicare covers allogeneic and autologous transplants. Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses.

1. Allogeneic hematopoietic stem cell transplantation (HSCT)

Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor's stem cells is obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect.

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

2. Autologous stem cell transplantation (AuSCT)

Autologous stem cell transplantation is a technique for restoring stem cells using the patient's own previously stored cells. Autologous stem cell transplants (AuSCT) must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high-dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

In its *February 2016 OIG* report, the OIG determined that Medicare paid for many stem cell transplant procedures incorrectly. The main finding was that providers billed these procedures as inpatient when they should have been submitted as outpatient or outpatient with observation services. The key points in the report include:

- According to an independent medical review contractor contracted by OIG for this report, stem cell transplants are routinely performed in the outpatient setting.
- Hospitals may have incorrectly thought that stem cell transplantation was on CMS's list of inpatient-only procedures.

The two-midnight rule

To assist providers in determining whether inpatient admission is appropriate for payment under Medicare Part A, CMS adopted the two-midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria to use when determining whether an inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

In general, the two-midnight rule states that:

- Inpatient admissions will generally be payable under Part A if the admitting practitioner expects the patient to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.

The two-midnight rule also specifies that all treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The two-midnight rule does not prevent the physician or other qualified practitioner from providing any service at any hospital, regardless of the expected duration of the service.

As of 2016, for stays for which the physician or other qualified practitioner expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician or other qualified practitioner. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.

Additional information

The OIG report is available at *https://oig.hhs.gov/oas/reports/region9/91402037.pdf*.

The section of the *National Coverage Determinations Manual* that deals with stem cell transplants for treatment of certain conditions is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf*.

You may want to review the following *MLN Matters*® articles for further information:

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- MM9620 - "Stem Cell Transplantation for Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease, and Myelodysplastic Syndromes" is at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9620.pdf*.
- MM6416 - "April 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)" is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6416.pdf*.
- MM4173 - "Stem Cell Transplantation" is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4173.pdf*.
- MM3797 - "Updated Requirements for Autologous Stem Cell Transplantation (AuSCT) for Amyloidosis" is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3797.pdf*.

There is a fact sheet on the two-midnight rule at *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-4.html*.

CMS provides further guidance on the two-midnight rule with responses to frequently asked questions at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf*.

Additional information is in a transcript of an MLN Connects® conference call discussing the two-midnight rule, which is available at *https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2-27-14MidnightRuleTranscript.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 22, 2017 - Initial article released.
- May 1, 2017 - The article was revised to make a number of clarifications and to delete the table that had been in the article.

MLN Matters® Number: SE1624 *Revised*
Related Change Request (CR) #: N/A
Article Release Date: May 1, 2017
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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*.

Implementation of modifier CG for type of bill 72x

Provider types affected

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

Provider action needed

Change request (CR) 9989 informs MACs about the implementation of modifier CG for dialysis claim lines that do not meet the MAC's medical justification requirements for dialysis treatments. Make sure that your billing staffs are aware of these changes.

Background

When the end-stage renal disease (ESRD) prospective payment system (PPS) was implemented in 2011, the Centers for Medicare & Medicaid Services (CMS) adopted a per treatment unit of payment. This per treatment unit of payment is the same base rate that is paid for all dialysis treatment modalities furnished by an ESRD facility (hemodialysis (HD) and the various forms of peritoneal dialysis (PD)). Consistent with CMS policy since implementation of the composite rate payment system in the 1980s, CMS also adopted the three-time weekly payment limit for HD under the ESRD PPS. When a beneficiary's plan of care requires more than three weekly dialysis treatments, whether HD or daily PD, CMS applies payment edits to ensure that Medicare payment on the monthly claim is consistent with the three-time weekly dialysis treatment payment limit. Thus, for a 30-day month, payment is limited to 13 treatments, and for a 31-day month payment it is limited to 14 treatments, with exceptions made for medical justification.

In order to accurately capture all treatments provided to a beneficiary, CMS is implementing a new modifier (CG – policy criteria applies) for the 72x type of bill (TOB) with revenue codes 0821 or 0881 and HCPCS 90999 when used in the billing of dialysis treatments for patients with ESRD in excess of the 13 or 14 monthly allowable treatments.

Note: This does not apply to training treatments (condition code 73 or 87). These services should be paid when modifier CG is present and they are within the current limitations.

Modifier CG (policy criteria applies) is used to identify dialysis treatments (CPT® 90999) in excess of 13 or 14 per month that do not meet medical justification requirements as defined by the MACs. This modifier shall be appended to the claim line for the date of service associated with the excess treatment. This modifier indicates that the facility attests the additional treatment does not meet medical justification requirements and should not be paid separately.

MACs will continue to use existing processes to determine medical justification for claim lines in excess of 13/14 per month that do not include the new modifier. When a claim line includes modifier CG and medical justification, the claim line should not be separately payable.

Medicare will deny claim lines on TOB 72x with revenue codes 0821 or 0881, HCPCS code 90999, and modifier CG using group code CO and claims adjustment reason code 96 (non-covered charge(s). At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.)

Additional information

The official instruction, CR 9989 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1849OTN.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: MM9989
Related Change Request (CR) #: CR 9989
Related CR Release Date: May 12, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1849OTN
Implementation Date: October 2, 2017

Outlier limitation on OPPS community mental health center services

Provider types affected

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

Provider action needed

Change request (CR) 9671 instructs Medicare shared systems maintainers and MACs to implement an outlier limitation on outpatient prospective payment system (OPPS) CMHC services. Make sure that your billing staffs are aware of these changes.

Background

In the 2017 OPPS final rule, the Centers for Medicare & Medicaid Services (CMS) finalized a limitation on outlier payments for CMHC services under the OPPS. Under these requirements, Medicare systems accumulate a year-to-date total during claims processing, for each CMHC provider, the overall total payments the CMHC provider has received and the total of outlier payments they have received. The total payment amount includes any outlier payments. These totals are then compared to determine whether a CMHC provider has been paid eight percent of its total payments for the year-to-date in outliers. Thus, an individual CMHC provider will receive no more than eight percent of its total CMHC OPPS payments in outlier payments. To make the outlier limitation more transparent to providers, a detail file of outlier payments will be created that each CMHC provider may review for the purpose of monitoring their payments accrued toward the outlier limitation.

MACs will use claim adjustment reason code 273 along with group code CO, rather than code 45, on the remittance advice of CMHC claims with dates of service on or after January 1, 2017, when an outlier amount is calculated but cannot be paid as a result of this rule. Also, MACs will use remittance advice remark code N523 in addition to claim adjustment reason code 273 along with group code CO on the remittance advice of CMHC claims with dates of service on or after January 1, 2017, when an outlier amount is calculated but cannot be paid.

Additional information

Please also see CR 9882, with updated language regarding the implementation of the CMHC outlier cap,

available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1782OTN.pdf*.

The official instruction, CR 9671, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1705OTN.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
May 12, 2017	Initial article released.

MLN Matters® Number: MM9671
Related Change Request (CR) #: CR 9671
Related CR Release Date: August 5, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R1705OTN
Implementation Date: January 3, 2017

July update to the 2017 Medicare physician fee schedule database

Provider type affected

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

Provider action needed

Change request (CR) 10104 informs MACs about the release of payment files based upon the 2017 Medicare physician fee schedule (MPFS) final rule. 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* November 15, 2016, to be effective for services furnished between January 1, 2017, and December 31, 2017. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

Following is a summary of the changes for the July update to the 2017 MPFSDB.

Effective for dates of service (DOS) on and after January 1, 2017, except as noted otherwise.

CPT®/ HCPCS	Action
20245	Global days = 000
52441	Endo base = 52000
64897	Co-surgery = 1
64902	Co-surgery = 1
J1725	Status = I, effective for DOS on or after July 1, 2017
P9072	Status = I, effective for DOS on or after July 1, 2017

The following new codes have been added to the HCPCS file effective May 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
0004U	Nfct ds dna 27 resist genes	Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate
0005U	Onco prst8 3 gene ur alg	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score

The following new codes from CR 10107 have also been added to the MPFSDB effective July 1, 2017 (see *MLN Matters*® article MM10107 when it is available) for code descriptions and additional information):

Code	Action
Q9984	Procedure status = N; there are no RVUs, payment policy indicators do not apply.
Q9985	Procedure status = E; there are no RVUs, payment policy indicators do not apply
Q9986	Procedure status = E; there are no RVUs, payment policy indicators do not apply
Q9988	Procedure status = X; there are no RVUs, payment policy indicators do not apply
Q9989	Procedure status = E; there are no RVUs, payment policy indicators do not apply

Refer to table on page 24 for new codes effective July 1, 2017.

Additional information

The official instruction, CR 10104, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3772CP.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
May 15, 2017	Initial article released.

MLN Matters® Number: MM10104
Related CR Release Date: May 12, 2017
Related CR Transmittal Number: R3772CP
Related Change Request (CR) Number: 10104
Effective Date: January 1, 2017
Implementation Date: July 3, 2017

See **MPFSDB**, next page

MPFSDB

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New HCPCS and CPT® category III codes added effective July 1, 2017

Code	Modifier	Short descriptor	Long descriptor	MPFSDB indicator information
Q9987		Pathogen test for platelets	Pathogen(s) test for platelets	Procedure status X; there are no RVUs, payment policy indicators do not apply.
0469T		Rta polarize scan oc scr bi	Retinal polarization scan, ocular screening with on-site automated results, bilateral	Procedure status N; there are no RVUs, payment policy indicators do not apply.
0470T	TC, 26	Oct skn img acquisj i&r 1st	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion	Procedure status C; PC/TC indicator 1; there are no RVUs, no other payment policy indicators apply.
0471T	TC, 26	Oct skn img acquisj i&r addl	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)	Procedure status C; PC/TC indicator 1; there are no RVUs, no other payment policy indicators apply.
0472T		Prgrmg io rta eltrd ra	Device evaluation, interrogation, and initial programming of intra- ocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional	Procedure dtatus C; there are no RVUs, payment policy indicators do not apply.
0473T		Reprgrmg io rta eltrd ra	Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	Procedure status C; there are no RVUs, payment policy indicators do not apply.
0474T		Insj aqueous drg dev io rsvr	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	Procedure status C; there are no RVUs, payment policy indicators do not apply.
0475T		Rec ftl car sgl 3 ch i&r	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional	Procedure status C; there are no RVUs, payment policy indicators do not apply.
0476T		Rec ftl car sgl elec tr data	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage	Procedure status C; there are no RVUs, payment policy indicators do not apply.
0477T		Rec ftl car sgl xrtj alys	Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result	Procedure status C; there are no RVUs, payment policy indicators do not apply.
0478T		Rec ftl car 3 ch rev i&r	Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional	Procedure status C; there are no RVUs, payment policy indicators do not apply.

July 2017 quarterly update for 2017 DMEPOS fee schedule

Provider type 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.

Provider action needed

Change request (CR) 10071 provides the July 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*, Chapter 23, Section 60 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

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, Section 1834 at *https://www.ssa.gov/OP_Home/ssact/title18/1834.htm*.

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 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 (CBAs), 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 tural ZIP code file is updated on a quarterly basis as necessary.

The 2017 DMEPOS and PEN fee schedules and the July 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 *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched*.

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

Effective July 1, 2017, the fee schedule amounts for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier 'KU' are deleted from the DMEPOS fee schedule file. These unadjusted fee schedule amounts have applied to wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). The fee schedule amounts associated with the KU modifier were mandated by Section 2 of Patient Access and Medicare Protection Act (PAMPA) effective for dates of service January 1, 2016, through December 31, 2016. Additionally, Section 16005 of the 21st Century Cures Act extended the effective date through June 30, 2017. The list of HCPCS codes to which this statutory section applied is available in Transmittal 3535, CR 9520 dated June 7, 2016.

Therapeutic continuous glucose monitor (CGM)

As part of this update, the fee schedule amounts for the following therapeutic CGM HCPCS codes are added to the DMEPOS fee schedule file effective for dates of service on or after July 1, 2017:

- K0553 - Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month's supply
- K0554 - Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system

See **DMEPOS**, next page

April 2017 quarterly update for 2017 DMEPOS fee schedule

***Note**: This article was revised May 5, 2017, to reflect a revised change request (CR) 9988 issued that day. The CR was revised to delete an example that was in the original CR. That example has been removed from the article. Also, the CR release date, transmittal number, and the web address of CR 9988 are revised in the article. All other information remains the same. This information was previously published in the March 2017 Medicare A Connection, page 25).*

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

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 *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched*.

See **APRIL**, next page

DMEPOS

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The fee schedule amounts apply a CMS ruling effective on or after January 12, 2017, for therapeutic CGMs. Additional information on the CMS ruling is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf*.

Additional information

The official instruction, CR 10071, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3760CP.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
May 2, 2017	Initial article released

MLN Matters® Number: MM10071
Related CR Release Date: April 28, 2017
Related CR Transmittal Number: R3760CP
Related Change Request (CR) # 10071
Effective Date: July 1, 2017
Implementation Date: July 3, 2017

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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 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.

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 four liters per minute (LPM) and portable oxygen is prescribed. The QF modifier is used to denote when the oxygen flow exceeds four 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 four 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 four liters per minute (LPM).

Additional information

To view the official instruction, CR 9982 issued to your MAC regarding this change, refer *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3768CP.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
May 5, 2017	Article revised to reflect revised CR 9988. The CR was revised to delete an example that was in the original CR. That example has been removed from the article. Also, the CR release date, transmittal number, and the web address of CR 9988 are revised in the article. All other information remains the same.

MLN Matters® Number: MM9988 *Revised*
Related Change Request (CR) #: CR 9988
Related CR Release Date: May 5, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3768CP
Implementation Date: April 3, 2017

New MSP type for liability set-aside arrangements

***Note**: This article was revised May 10, 2017, due to the release of an updated change request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same. This information was previously published in the March 2017 Medicare A Connection, page 22.*

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 CR 9893. To comply with the Government Accountability Office (GAO) final report titled *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 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 claim 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/R1845OTN.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/*.

Document history

Date of change	Description
May 10, 2017	The article was revised due to the release of an updated CR. The CR date, transmittal number and the link to the transmittal changed.

See **MSP**, next page

Payment for moderate sedation services furnished with colorectal cancer screening tests

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers submitting claims to Part A and B Medicare administrative contractors (MACs) for sedation services furnished with colorectal cancer screening tests.

Provider action needed

Change request (CR) 10075 ensures accurate program payment for moderate sedation services furnished in conjunction with screening colonoscopy services for which the beneficiary should not be charged the coinsurance or deductible. The coinsurance and deductible for these services are waived, but due to coding changes and additions to the Medicare physician fee schedule (MPFS) database the payments for 2017 would not be accurate without this CR. Please make your billing staff aware of these changes.

Background

Section 4104 of the Affordable Care Act defined the term "preventive services" to include "colorectal cancer screening tests" and, as a result, it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Social Security Act for screening colonoscopies. In addition, the ACA amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes moderate sedation services as an inherent part of the screening colonoscopy procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the 2017 PFS final rule, the Centers for Medicare & Medicaid Services (CMS) modified coding and reporting of procedural services that include moderate sedation as an inherent part of the service, including for screening colonoscopies. CR 10075 operationalizes the existing waiver of deductible and coinsurance for moderate sedation services furnished in conjunction with and in support of colorectal cancer screening tests. Effective January 1, 2017, beneficiary coinsurance and deductible continues to not apply to the following moderate sedation claim lines when furnished in conjunction with screening colonoscopy services and when billed with modifier 33 or modifier PT:

- HCPCS code G0500: Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; patient age five years or older (additional time may be reported with 99153, as appropriate).
- CPT® code 99153: Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intra-service time (List separately in addition to code for primary service).

MACS will not search their files to either retract payment for claim lines already paid or to retroactively pay claim lines with HCPCS code G0500 or CPT® code 99153. However, MACs will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 10075, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3763CP.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
May 1, 2017	Initial article released

MLN Matters® Number: MM10075
Related CR Release Date: April 28, 2017
Related CR Transmittal Number: R3763CP
Related Change Request (CR) Number: 10075
Effective Date: January 1, 2017
Implementation Date: October 2, 2017

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Date of change	Description
February 17, 2017	Initial article released

MLN Matters® Number: MM9893 *Revised*
Related Change Request (CR) #: CR 9893
Related CR Release Date: May 10, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1845OTN
Implementation Date: October 2, 2017

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/R3754CP.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

- **February 3, 2017** – Initial article released.
- **April 21, 2017** – The article was revised to reflect a revised CR 9876 issued that day. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

MLN Matters® Number: MM9876
Related Change Request (CR) #: CR 9876
Related CR Release Date: April 21, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3754CP
Implementation Date: July 3, 2017

Screening for hepatitis B virus infection

Provider types affected

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

Provider action needed

Change request (CR) 9859 provides that the Centers for Medicare & Medicaid Services (CMS) has determined that, effective September 28, 2016, Medicare will cover screening for Hepatitis B Virus (HBV) infection when performed with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations. **Medicare coinsurance and the Part B deductible are waived for this additional preventive service**. You should ensure that your billing staffs are aware of this coverage change.

Background

Pursuant to Section 1861(ddd) of the Social Security Act (the Act), CMS may add coverage of "additional preventive services" through the national coverage determination (NCD) process. The preventive services must meet all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability.
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF).
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

The USPSTF has updated its recommendations for HBV screening, and CMS has reviewed these recommendations and supporting evidence; and has determined that the evidence is adequate to conclude that screening for HBV infection is reasonable and necessary for individuals entitled to benefits under Part A or enrolled under Part B, as described below.

Effective for services performed on or after September 28, 2016, Medicare will cover screening for HBV infection, when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, within the context of a primary care setting with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, for beneficiaries who meet either of the following conditions:

1. Asymptomatic, non-pregnant adolescents and adults at high risk for HBV infection. "High risk" is defined as persons born in countries and regions with a high prevalence of HBV infection (that is, ≥ 2%), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥ 8%), HIV positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection. In addition, CMS has determined that repeated screening would be appropriate annually for beneficiaries with continued high risk persons. Testing is covered annually only for persons who have continued high risk (men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) who have not received hepatitis B vaccination.
2. A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative hepatitis B surface antigen (HBsAg) test results.

For the purposes of CR 9859:

- The determination of 'high risk for HBV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.
- A primary care setting is defined by the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings **not** considered primary care settings under this definition.

Key points of CR 9859

Applicable Healthcare Common Procedure Coding System (HCPCS) code

Effective for claims with dates of service on or after September 28, 2016, the claim processing instructions for payment of screening for hepatitis B virus will apply to the following HCPCS and CPT® codes:

- HBV screening for asymptomatic, non-pregnant adolescents and adults at high risk - code G0499
- HBV screening for pregnant women - CPT® codes 86704, 86706, 87340, and 87341

Types of bill (TOB) for institutional claims

Effective for claims with dates of service on or after September 28, 2016, you should use the following TOBs when submitting claims with G0499, 87340, 87341, 86704,

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or 86706 for HBV screening:

- Outpatient hospitals - TOB 13x (payment based on outpatient prospective payment system)
- Non-patient laboratory specimen - TOB 14x (payment based on laboratory fee schedule)
- Critical access hospitals (CAHs) - TOB 85x, (payment based on reasonable cost when the revenue code is not 096x, 097x, and 098x)
- End-stage renal disease (ESRD) - TOB 72x (payment based on ESRD prospective payment system when submitting code G0499 with diagnosis code N18.6. HBV is not separately payable for ESRD TOB 72x.)

Professional billing requirements

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening **only when services are ordered** by the following provider specialties found on the provider's enrollment record:

- 01 - General practice
- 08 - Family practice
- 11 - Internal medicine
- 16 - Obstetrics/gynecology
- 37 - Pediatric medicine
- 38 - Geriatric medicine
- 42 - Certified nurse midwife
- 50 - Nurse practitioner
- 89 - Certified clinical nurse specialist
- 97 - Physician assistant

Claims submitted by providers other than the specialty types noted above will be denied.

Additionally, for claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening only when submitted with one of the following place of service (POS) codes:

- 11 - Physician's office
- 19 - Off-campus outpatient hospital
- 22 - On-campus outpatient hospital
- 49 - Independent clinic
- 71 - State or local public health clinic
- 81 - Independent laboratory

Claims submitted without one of the POS codes noted above will be denied.

Diagnosis code reporting requirements

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for G0499 for HBV screening only when services are reported with both of the following diagnosis codes denoting high risk:

- Z11.59 - Encounter for screening for other viral disease
- Z72.89 - Other problems related to life style

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for G0499 for subsequent visits, only when services are reported with the following diagnosis codes:

- Z11.59 and one of the high-risk codes below:
  - F11.10-F11.99
  - F13.10-F13.99
  - F14.10-F14.99
  - F15.10-F15.99
  - Z20.2
  - Z20.5
  - Z72.52
  - Z72.53

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT® codes 86704, 86706, 87340 and 87341) in pregnant women only when services are reported with one of the following diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases, **and one of the following:**
  - Z34.00 - Encounter for supervision of normal first pregnancy, unspecified trimester
  - Z34.80 - Encounter for supervision of other normal pregnancy, unspecified trimester
  - Z34.90 - Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
  - O09.90 - Supervision of high risk pregnancy, unspecified, unspecified trimester

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT® codes 86704, 86706, 87340, and 87341) in pregnant women at high risk only when services are reported with one of the following diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases; and
- Z72.89 - Other problems related to lifestyle, and also one of the following:

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester

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Code	Description
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

Claim/service denial

When denying payment for HBV screening use, your MAC will use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), or group codes.

When denying services submitted on a TOB other than 13x, 14x, or 85x, they will use:

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

When denying services when HCPCS G0499 is paid in history for claims with dates of service on and after September 28, 2016, or if the beneficiary's claim history shows claim lines containing CPT® codes 86704, 86706, 87340, and 87341 submitted in the previous 11 full months they will use the following messages:

- CARC 119 - "Benefit maximum for this time period or occurrence has been reached."
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 with or without GA modifier or a claim –line is received with 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).

When denying services for G0499, when ICD-10 diagnosis code Z72.89 and Z11.59 are not present on the claim, MACs will use:

- CARC 167 - "This (these) diagnosis(es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO

Denying services for HBV screening, HCPCS G0499, when ICD-10 diagnosis code Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93 is present on the claim:

- CARC 167 – "This (these) diagnosis(es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code: CO (contractual obligation)

When denying services for G0499 for subsequent visits, when ICD-10 diagnosis code Z11.59 and one of the following high-risk diagnosis codes: F11.10- F11.19, F13.10 - F13.99, F14.10 - F14.99, F15.10 - F15.99, Z20.2, Z20.5, Z72.52, or Z72.53 are not present on the claim, MACs will use:

- CARC 167 - "This (these) diagnosis(es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available

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at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.

- Group code CO

When denying claim lines for G0499 without the appropriate POS code, MACs will use:

- CARC 171 - Payment is denied when performed by this type of provider on this type of facility. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428 - Not covered when performed in certain settings.
- Group code CO

When denying claim lines for G0499 that are not submitted from the appropriate provider specialties, MACs will use:

- CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service billed. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group code CO (contractual obligation) - Assigning financial liability to the provider (if a claim line-item is received with a GZ modifier indicating no signed ABN is on file).

When denying services where previous HBV screening, HCPCS 86704, 86706, 87340, or 87341, is paid during the same pregnancy period or more than two screenings are paid to women that are at high risk, they will use:

- CARC 119 - "Benefit maximum for this time period or occurrence has been reached."
- RARC N362 - "The number of days or units of service exceeds our acceptable maximum."
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with 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).

When denying claim lines for HBV screening, HCPCS G0499 for a subsequent HBV screening test for non-pregnant, high-risk beneficiary when a claim line for an initial HBV screening has not yet been posted in history, use the following messages:

- CARC B15 - This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code - CO (contractual obligation).

When denying services for HBV screening, HCPCS 86704, 86706, 87340, and 87341 that are billed without the appropriate diagnosis code MACs will use:

- CARC 50 - These are non-covered services because this is not deemed a "medical necessity" by the payer. **Note**: Refer to the 835 Healthcare Policy identification Segment (loop 2110 Service Payment information REF), if present.
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).

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- Group code CO (contractual obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Additional notes

- HCPCS code G0499 will appear in the January 1, 2018, clinical laboratory fee schedule (CLFS), in the January 1, 2017, integrated outpatient code editor (IOCE), and in the January 1, 2017, Medicare physician fee schedule (MPFS) with indicator 'X'. HCPCS code G0499 will be effective retroactive to September 28, 2016, in the IOCE.
- Your MAC will not search for claims containing HCPCS G0499 with dates of service on or after September 28, 2016, but may adjust claims that you bring to their attention.
- You should be aware that the revision to the *Medicare National Coverage Determinations Manual* is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs) (see 42 CFR Section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See Section 1869(f)(1)(A)(i) of the Social Security Act.)
- MACs will apply contractor pricing to claim lines with G0499 with dates of service September 28, 2016, through December 31, 2017.
- Deductible and coinsurance do not apply to G0499.

Additional information

The official instruction, CR 9859, was issued to your MAC via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3761CP.pdf*. The second transmittal updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R195NCD.pdf*.

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

Document history

Date	Description
May 17, 2017	The article was changed to clarify language under *Professional Billing Requirements.* It now reads, only when services **are ordered** by the following provider specialties found on the provider's enrollment record.
May 4, 2017	Initial article released.

MLN Matters® Number: MM9859
Related Change Request (CR) #: CR 9859
Related CR Release Date: April 28, 2017
Effective Date: September 28, 2016
Related CR Transmittal #: R3761CP and R195NCD
Implementation Date: January 1, 2018

Episode payment model operations

***Note**: This article has been rescinded as change request (CR) 9916 was rescinded. The CR will be replaced at a later date. This information was previously published in the March 2017 Medicare A Connection, pages 26-29.*

MLN Matters® Number: MM9916 *Rescinded*
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

Reporting of type of bill 014x for billing screening of hepatitis C virus in adults

***Note**: This article was revised May 2, 2017, to correct the TOBs for the screening of HCV other than non-patient laboratory specimen. All other information is the same. This information was previously published in the November 2015 Medicare A Connection, page 15.*

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries related to screening of hepatitis C virus (HCV) in adults.

Provider action needed

This article is based on change request (CR) 9360, which adds type of bill (TOB) 014x (hospital other Part B) as an applicable TOB for the screening of HCV when submitted for non-patient laboratory specimen (HCPCS code G0472). Transmittal 3215, CR 8871, titled "Screening for hepatitis C virus (HCV) in adults", omitted TOB 014x from the list of applicable TOBs for HCV screening. Payment for these services submitted on TOB 014x will be based on the laboratory fee schedule. Make sure your billing personnel are aware of this change.

Background

Appropriate TOBs for the screening of HCV other than non-patient laboratory specimen remain the same:

- 013x
- 085x

Providers report TOB 014x when submitting claims for screening for HCV when provided to non-patient laboratory specimens.

In addition, MACs will apply the same logic for G0472 on TOB 14x as described in *MLN Matters*® articles *MM8871* and *MM9200*.

Note that MACs will not search for claims with G0472, submitted under TOB 014x with dates of service on or after June 2, 2014, but received before April 4, 2016, but the MACs may adjust claims that are brought to their attention.

Additional information

The official instruction, CR 9360, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3393CP.pdf*.

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

Document history

Date of change	Description
May 2, 2017	The article was revised to correct the TOBs for the screening of HCV other than non-patient laboratory specimen.
November 16, 2015	Initial article released

MLN Matters® Number: MM9360 *Revised*
Related Change Request (CR) #: CR 9360
Related CR Release Date: November 5, 2015
Effective Date: June 2, 2014
Related CR Transmittal #: R3393CP
Implementation Date: April 4, 2016

Upcoming provider outreach and educational events

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

Medicare Part A/B changes and regulations

Date: Wednesday, June 14
Time: 2:00-3:30 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0372840.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 April 27, 2017

MLN Connects® for April 27, 2017
View this edition as a PDF

News & Announcements

- Clinicians: MIPS Participation Status Letter
- Open Payments Program Year 2016 Review and Dispute Period Ends May 15
- EHR Incentive Programs: Submit Comments on Proposed Changes by June 13
- IMPACT Act Data Elements Public Comments Due June 26
- IRF Quality Reporting Program Review and Correct Reports Available
- Quality Payment Program: New Videos for Small, Rural, and Underserved Practices
- EHR Incentive Programs: Public Health Agency and Clinical Data Registry Reporting
- Updated Advance Beneficiary Notice
- Antipsychotic Drug use in Nursing Homes: Trend Update
- April is STD Awareness Month: Talk, Test, Treat

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities

Upcoming Events

- IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2
- Comparative Billing Report on Transitional Care Management Webinar — June 21

Claims, Pricers & Codes

- Hospitals and SNFs: Claims Hold Related to VA Claims

Medicare Learning Network® Publications & Multimedia

- Next Generation ACO – All Inclusive Population Based Payment Implementation *MLN Matters*® Article — New
- Open Payments Call: Audio Recording and Transcript — New
- Medicare Home Health Benefit Web-Based Training Course — Revised
- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised
- Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Revised
- PECOS FAQs Booklet — Reminder

MLN Connects® Special Edition – Friday, April 28, 2017

In This Edition:

1. Skilled Nursing Facilities: Proposed FY 2018 Payment and Policy Changes
2. Inpatient Rehabilitation Facilities: Proposed FY 2018 Payment and Policy Changes
3. Medicare Hospice Benefit: Proposed FY 2018 Updates to the Wage Index and Payment Rates

Skilled Nursing Facilities: Proposed FY 2018 Payment and Policy Changes

CMS issued a proposed rule (CMS-1679-P) outlining proposed FY 2018 Medicare payment rates and quality programs for Skilled Nursing Facilities (SNFs). Additionally, CMS released an Advance Notice of Proposed Rulemaking (CMS-1686-ANPRM), which solicits comment on potential revisions to the SNF payment system, based on research conducted under the SNF Payment Models Research project.

Proposed Rule Details:

- Changes to payment rates under the SNF Prospective Payment System (PPS)
- SNF Quality Reporting Program
- SNF Value-Based Purchasing (VBP) Program
- End-Stage Renal Disease Quality Incentive Program
- Request for Information
- Survey team composition

For More Information:

- *Proposed Rule*: CMS will accept comments until June 26
- *Advanced Notice of Proposed Rulemaking*: CMS will accept comments until June 26
- *SNF PPS Payment Model Research* web page
- *SNF PPS* website
- *SNF QRP* website
- *SNF VBP* Program website

See the full text of this excerpted *CMS Fact Sheet* (issued April 27).

Inpatient Rehabilitation Facilities: Proposed FY 2018 Payment and Policy Changes

CMS issued a proposed rule (CMS-1671-P) outlining proposed FY 2018 Medicare payment policies and rates for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program (QRP). In addition to the proposed rule, CMS is releasing a Request for Information to welcome continued feedback on the Medicare Program.

Proposed Rule Details:

- Proposed updates to IRF payment rates
- Proposed removal of 25 percent payment penalty for late transmissions of the IRF- Patient Assessment Instrument
- Proposed refinements to the 60 percent rule presumptive methodology

- Solicitation of comments regarding the criteria used to classify facilities for payment under the IRF PPS
- Proposed technical IRF process revisions
- Proposed changes to the IRF QRP

For More Information:

- *Proposed Rule* CMS will accept comments until June 26

See the full text of this excerpted *CMS Fact Sheet* (issued April 27).

Medicare Hospice Benefit: Proposed FY 2018 Updates to the Wage Index and Payment Rates

CMS issued a proposed rule (CMS-1675-P) that would update FY 2018 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries and releases Request for Information within the proposed rule. This proposed rule would update the hospice wage index, payment rates, and cap amount for FY 2018.

Proposed Rule Details:

- Routine annual rate setting changes
- Discussion and solicitation of comments regarding sources of clinical information for certifying terminal illness
- Hospice CAHPS® Experience of Care Survey
- Quality measure concepts under consideration for future years
- New data collection mechanisms under consideration: Hospice Evaluation & Assessment Reporting Tool (HEART)
- Public reporting

For More Information:

- *Proposed rule*: CMS will accept comments until June 26
- *Hospice Center* web page

See the full text of this excerpted *CMS Fact Sheet* (issued April 27).

MLN Connects® for May 4, 2017

MLN Connects® for May 4, 2017

View this edition as a PDF

News & Announcements

- DMEPOS Revised Blended Fee Schedule Amounts
- TEP on SNF QRP Development and Maintenance of Quality Measures: Nominations due May 12
- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
- MIPS: Submit Measures for the Advancing Care Information Performance Category by June 30
- Hospice Item Set V2.00.0 Receives OMB Approval
- EHR Incentive Programs: Review 2017 Program Requirements
- Hand Hygiene Day is May 5

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly

Upcoming Events

- MIPS Group Reporting 101 Webinar — May 11

Medicare Learning Network® Publications & Multimedia

- Medicare Shared Savings Program Call: Audio Recording and Transcript — New
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Web-Based Training Course — Revised
- Medicare Ambulance Transports Booklet — Revised
- Looking for the Latest National Medicare Policy Information?

MLN Connects® for May 11, 2017

MLN Connects® for May 11, 2017

View this edition as a PDF

News & Announcements

- Open Payments Program Year 2016 Review and Dispute Period Ends May 15
- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
- Lookup Tool to Help Determine MIPS Participation Status
- Updated CY 2018 eCQM Specifications Available
- New PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
- Requesting Appeal Redeterminations
- National Women's Health Week Kicks off on Mother's Day

Provider Compliance

- CMS Provider Minute Video: Coudé Tip Catheters

Medicare Learning Network® Publications & Multimedia

- Global Surgery Call: Audio Recording and Transcript — New
- Emergency Preparedness Call: Audio Recording and Transcript — New
- Resources for Medicare Beneficiaries Booklet — Revised
- SNF Billing Reference Booklet — Revised
- Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Revised

MLN Connects® for May 18, 2017

MLN Connects® for May 18, 2017
View this edition as a PDF

News & Announcements

- Clinical Laboratories: Lab Data Due May 30
- SNF Quality Reporting Program: Submission Deadline Extended to June 1
- National Mental Health Awareness Month 2017

Provider Compliance

- Reporting Changes in Ownership

Claims, Pricers & Codes

- 2018 ICD-10-PCS Files Available

Upcoming Events

- Quality Payment Program Participation Criteria Webinar – May 22
- National Partnership to Improve Dementia Care and QAPI Call – June 15

Medicare Learning Network® Publications & Multimedia

- Updated Manual Guidelines for Electronic Funds Transfer Payments and Change of Ownership MLN Matters Article – New

- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article – Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-Based Training Course – Reminder

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.

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