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

In this issue

MLN Connects® Provider eNews – Special Edition

Thursday, July 13, 2017

In this edition:

- Hospital Outpatient, ASC: CMS Proposes 2018 Policy and Rate Changes
- Physician Fee Schedule: CMS Proposes 2018 Payment and Policy Updates

Hospital Outpatient, ASC: CMS Proposes 2018 Policy and Rate Changes

Proposed rule and Request for Information promote improvements to quality, accessibility, and affordability of care

On July 13, CMS issued a proposed rule that updates payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed rule is one of several for 2018 that reflect a broader strategy to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility and innovation in the delivery of care.

The OPPS and ASC payment system are updated annually to include changes to payment policies, payment rates, and quality provisions for those Medicare patients who receive care at hospital outpatient departments or receive care at surgical centers. Among the provisions in this rule, CMS is proposing to change the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B program. The proposed rule also includes a provision that would alleviate some of the burdens rural hospitals experience in recruiting physicians by placing a two-year moratorium on the direct supervision requirement currently in place at rural hospitals and critical access hospitals. In addition, CMS is releasing within the proposed rule a Request for Information to welcome continued feedback on flexibilities and efficiencies in the Medicare program.

For More Information:

- *Proposed Rule*
- *Fact Sheet*

See the full text of this excerpted *Press Release* (issued July 13).

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

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Articles included in the *Medicare A Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

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

Note: *The article was revised June 29, 2017, to reflect a revised change request (CR) 9911 issued June 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. Clarifications are also made to the second paragraph of the "Background" section. All other information remains the same. This information was previously published in the May 2017 Medicare A Connection, page 1.*

Provider type 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

CR 9911 modifies the Medicare claims 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 claims 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.

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. 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 payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the *Provider Reimbursement Manual (PRM)*.

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 claims 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 claim 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 claims 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.

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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/R3802CP.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.
- June 29, 2017 - The article was revised to reflect a revised CR 9911 issued June 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. Clarifications were also made to the second paragraph of the *Background* section. All other information remains the same.

MLN Matters® Number: MM9911
Related CR Release Date: June 28, 2017
Related CR Transmittal Number: R3802CP
Related Change Request (CR) Number: CR9911
Effective Date: For claims processed on or after October 2, 2017
Implementation Date: October 2, 2017

Internet Only manual update to Pub. 100-04, Chapter 15

Provider type affected

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

What you need to know

Change request (CR) 10143 corrects errors in Chapter 15, Section 20.1.4 of the *Medicare Claims Processing Manual*.

Background

CR 10143 corrects errors in Chapter 15, Section 20.1.4 of the *Medicare Claims Processing Manual*. These changes are being made to correct minor typographical errors. No policy, processing, or system changes are anticipated. The change specifies that the year that is associated with the Medicare Modernization Act 2003.

Additional information

The official instruction, CR10143, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3800CP.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
July 18, 2017	Initial article released

MLN Matters® Number: MM10143
Related CR Release Date: June 23, 2017
Related CR Transmittal Number: R3800CP
Related Change Request (CR) Number: CR10143
Effective Date: July 25, 2017
Implementation Date: July 25, 2017

Modernized national plan and provider enumeration system

Provider type affected

This *MLN Matters*® article is intended for all health care providers – users of the national plan and provider enumeration system (NPPES) to obtain, or update a national provider identifier (NPI) and to maintain their NPI account. This includes all physicians, providers and suppliers–it is not limited or restricted to Medicare.

Provider action needed

The Centers for Medicare & Medicaid Services has modernized the NPPES (NPPES 3.0) that now has unified login for type one and type two providers which increases security, provides new surrogacy functionality, has a more responsive user interface (UI) and a streamlined NPI application process. All NPPES users who obtain and manage NPI account information should be aware of these new and improved features/processes, especially those who support type two providers. NPPES has implemented a more efficient way of accessing type two NPI accounts so providers no longer need separate credentials for type two accounts and are no longer inclined to share these credentials.

Background

The NPI is the standard for a unique identifier for health care providers for use in the health care system. NPPES is the application that health care providers must use to be awarded an NPI number. Within the NPPES, there are two types of providers:

- Type one providers – health care providers who are individuals, including physicians, dentists, and all sole proprietors (an individual is eligible for only one NPI.)
- Type two providers – health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

For more information on the national provider number please visit *https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/downloads/NPIfinalrule.pdf*.

New NPPES impact on type one providers

Type one providers who already have an account in the identity & access (I&A) management system may login to NPPES without incident. Type one providers who do not have an I&A account will need to create an account by visiting *https://nppes.cms.hhs.gov/IAWeb/login.do*.

Under the modernized NPPES, surrogates of type 1 providers will have access to their type one provider's NPI records.

For more information on the identity & access management system please visit *https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf*.

New NPPES impact on type two providers

In the past, the sharing of login credentials between type

two providers and surrogates posed great security risks including fraud and provider identity theft. The new unified login and surrogacy helps lessen these risks and increase account security. Type two provider users will need I&A authentication credentials to access the modernized NPPES. Users may obtain these in the I&A system by going to *https://nppes.cms.hhs.gov/IAWeb/login.do*. The authorized officials (AO) and delegated officials (DO) in I&A of type two providers will be able to access all NPIs under the employer identification number (EIN) on the type two provider with an organization EIN. Users can claim NPIs using their legacy type two usernames and passwords after they login with an I&A account. As an additional convenience, large organizations can contact the enumerator to get access to their NPIs. More information on the types of possible user roles is available at *https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf*.

Key features of the modernized NPPES

Some of the key features of the modernized and more responsive UI include:

- If users have an I&A user ID and password, they now can use those credentials to login to NPPES and they can access all NPIs from one unified account.
- Users can save applications that are not fully complete and may continue where they left off when they return to the NPPES.
- NPPES will have smart filters that only display entries containing the data entered by users to filter away unnecessary information.
- Users may add more than one practice location to their NPI application.
- All taxonomy information may be completed on one page due to the smart filter technology of NPPES 3.0.
- Surrogacy allows administrative users the ability to update records in NPPES on behalf of a provider.
- NPPES 3.0 provides a help option to give assistance to the user based on the screen on which they are working.

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- Increased security because NPPES now uses surrogacy functionality for type two NPIs to prevent sharing of type two login credentials.

Electronic file interchange (EFI) features

NPPES 3.0 will continue to allow providers and surrogates to submit multiple NPI applications at one time using comma-separated values (CSV) files. To use the EFI feature, the users will need to apply for EFI access. This can be done by logging into NPPES and clicking the 'manage EFI' button on the bottom of the NPPES homepage. The EFI access application is pre-populated with some of the user's information pre-filled when it is generated. For more information on EFI functionality please visit *https://nppes.cms.hhs.gov/webhelp/nppeshelp/EFI%20HELP%20PAGE.html*.

Data dissemination file (DDS) enhancements

NPPES will generate weekly and monthly org other name, practice location addresses, and endpoint information files. The weekly files will have updates of the information that changes from week to week, while the monthly files will generate regardless of updated information. DDS files with PII will continue to be delivered to stakeholders, while DDS files without PII will continue to be delivered to *https://download.cms.gov/nppes/NPI_Files.html*.

New Optional Fields in NPPES 3.0

The following new fields will allow the user to give more information about the provider and the practice location:

- Primary languages
- Secondary languages
- Race and ethnicity
- Accessibility of the location to users with mobility disabilities
- Provider's office hours of operation
- Provider's direct email address

Frequently asked questions

Feel free to visit the NPPES web help guide to see solutions to frequently asked questions. That guide is available at *https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html*.

Additional information

Additional Information on NPPES is available at the following links:

- *https://www.youtube.com/watch?v=BOJCAj1P2u8&feature=youtu.be*
- *https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html#How-can-I-gain-access-to-my-Type-2-NPI*
- *https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html#Why-cant-I-use-my-Type-2-NPI-User-ID-and-Password-to-log-into-NPPES-to-access-my-NPI*
- *https://nppes.cms.hhs.gov/IAWeb/warning.do?fwdurl=/*

If you have any questions, please contact the NPI enumerator by phone at 1-800-465-3203 (NPI Toll-Free) or 1-800-692-2326 (NPI TTY), by email at *customerservice@npienumerator.com* or by regular mail at:

NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

Document history

Date of change	Description
June 27, 2017	Initial article released

MLN Matters® Number: SE17016
Article Release Date: June 27, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2017, must be paid before the end of business March 31, 2017.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department web page *https://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/rates.htm* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 2.375 percent is in effect through December 31, 2017.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

Implementing FISS updates to accommodate Section 603 Bipartisan Budget Act of 2015 - phase 2

Provider types affected

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

Provider action needed

Change request (CR) 9907 announces that, starting January 1, 2017, off-campus outpatient department(s) of a provider services that fall under the Bipartisan Budget Act of 2015 (§603) are required to be correctly identified. If a hospital claim is submitted with a service facility location that was not included on the CMS 855A enrollment form, the claim will be returned to the provider (RTP) until the CMS-855A enrollment form and claim processing system are updated. Make sure your billings staffs are aware of these changes.

Background

The Social Security Act (*Section 1833 (t)*) as amended by the Bipartisan Budget Act of 2015 (*Section 603*), authorizes the Centers for Medicare & Medicaid Services (CMS) to implement amended policies related to treatment of off-campus outpatient department(s) of a provider services.

Hospital providers are required to include all practice locations on the *CMS-855A* enrollment form, and CMS has performed a re-validation process (March 25, 2011–March 23, 2015) where in the last four years all hospital providers have completed an 855A enrollment form to either:

1. Initially enroll in Medicare,
2. Add a new practice location, or
3. Revalidate its enrollment information.

Starting January 1, 2017, off-campus outpatient department(s) of provider services that fall under the Bipartisan Budget Act of 2015 (§603) are required to be correctly identified.

If a hospital claim is submitted with a service facility location that was not included on the CMS-855A enrollment form, it will be returned to the provider (RTP) until the hospital updates its CMS-855A enrollment form and Medicare's claim processing system are updated accordingly.

CR 9907 also requires that either modifier PO or PN be present on all service lines with HCPCS codes when the service facility address is present. For more details on these modifiers please review *MLN Matters*® article *MM9930*.

Collection and retention of CMS-855 enrollment data has been cleared through a Paperwork Reduction Act Notice in the Federal Register. The authority for the various types of data to be collected is found in:

- The Social Security Act (Sections *1816*, *1819*, *1833*, *1834*, *1842*, *1861*, *1866*, and *1891*), and
- The *Code of Federal Regulations* (*42 CFR Chapter IV, Subchapter A*).

Additional information

The official instruction, CR 9907, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1783OTN.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: MM9907
Related Change Request (CR) #: CR 9907
Related CR Release Date: February 2, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R1783OTN
Implementation Date: July 3, 2017

Fiscal year 2014 S-10 revisions

Amended cost reports must be received by September 30, 2017

Some inpatient prospective payment system (IPPS) hospitals have requested the Centers for Medicare & Medicaid Services (CMS) provide them with an additional opportunity to revise the worksheet S-10 submitted with their fiscal year (FY) 2014 cost reports (starting on or after October 1, 2013, and prior to October 1, 2014). Amended FY 2014 cost reports due to revised or initial submissions of worksheet S-10 received by Medicare administrative contractors (MAC) on or before September 30, 2017, will be uploaded to the health care provider cost report information system (HCRIS) by December, 2017. Providers must follow the current requirements for electronic submission of cost reports found at 42 CFR §413.24(f)(4), which includes submitting:

- Hard copy of a settlement summary
- Statement of certain worksheet totals found within the electronic file
- Statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report

Requests to amend or submit FY 2014 worksheet S-10 received after September 30, 2017, will still be accepted under normal timelines and procedures. Revisions to worksheet S-10 from other fiscal years, revisions to other worksheets of the FY 2014 cost reports, or revisions to worksheet S-10 by non-IPPS hospitals are not subject to this instruction.

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 *https://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 *https://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 *https://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.

New Medicare cards

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires the Centers for Medicare & Medicaid Services (CMS) to remove Social Security numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

Distribution of new Medicare cards will begin April, 2018. Resources are available to prepare you for this change at *https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp*.

Retired LCDs

Collagenase clostridium histolyticum (Xiaflex®) – retired Part A and Part B LCD

LCD ID number: L33280 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the collagenase clostridium histolyticum (Xiaflex®) 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 July 06, 2017.** First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Intravitreal bevacizumab (Avastin®) – retired Part A and Part B LCD

LCD ID number: L33504 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for intravitreal bevacizumab (Avastin®) is being retired based on the development of new LCD (L36962) vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases.

Effective date

The retirement of this LCD is effective for services rendered **on or after July 24, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Ranibizumab (Lucentis®) – retired Part A and Part B LCD

LCD ID number: L33407 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for ranibizumab (Lucentis®) is being retired based on the development of new LCD (L36962) vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases.

Effective date

The retirement of this LCD is effective for services rendered **on or after July 24, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.

Revisions to LCD

Bendamustine hydrochloride (Treanda®, Bendeka™) – revision to the Part A and Part B LCD

LCD ID number: L33268 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for bendamustine hydrochloride (Treanda®, Bendeka™) was revised to add the indication "non hodgkins's lymphoma (NHL) - Adult T-cell Leukemia/Lymphoma" to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD under "off-labeled Indications". Also, the ICD-10-CM codes C91.50 and C91.52 were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) codes J9033 and J9034. 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 July 06, 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*.

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

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

Based on change request (CR) 9982 (ICD-10 Coding Revisions to National Coverage Determination [NCDs]), the local coverage determination (LCD) was revised to add ICD-10-CM diagnosis code Z86.000 for Healthcare Common Procedure Coding System (HCPCS) codes G0204, G0206, and G0279.

Effective date

This LCD revision is effective for claims processed **on or after July 3, 2017**, for services rendered **on or after January 1, 2017**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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Trastuzumab (Herceptin®) – revision to the Part A and Part B LCD

LCD ID number: L34026 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the LCD for trastuzumab (Herceptin®) was revised in the "ICD-10 Codes that Support Medical Necessity" section of the LCD to add ICD-10-CM diagnosis codes C16.1-C16.9. Also, the LCD was revised, in the "Utilization Guidelines" section of the LCD under "Dosage and Administration" to remove the 440 mg per vial supply and replace it with current Food and Drug Administration (FDA) label dosage forms and strengths; 150 mg single-dose vial and 420 mg multiple-dose vial. 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 July 14, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/*

medicare-coverage-database/overview-and-quick-search.aspx.

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

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

Additional Information

Non-coronary and non-cerebrovascular angioplasty with or without stent placement – retired Part A and Part B draft LCD

LCD ID number: DL36971 (Florida, Puerto Rico/U.S. Virgin Islands)

The draft local coverage determination (LCD) for non-coronary and non-cerebrovascular angioplasty with or without stent placement is being retired. The draft LCD was posted for the 45-day comment period the week of September 19, 2016, which was viewable to the public on September 29, 2016. The contractor would like to thank those who submitted comments; however, due to multiple coding descriptor changes and new codes implemented with the annual 2017 Healthcare Common Procedure Coding System (HCPCS) update, the contractor has retired the current draft LCD.

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FY 2018 and after payments to SNFs that do not submit required quality data

Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9944 reminds SNFs of payment reductions in fiscal year (FY) 2018, and each subsequent year, for SNFs that do not submit required quality data to Medicare.

Background

The Improving Medicare Post-Acute Care Transformation Act of 2014 (*IMPACT Act*) added Section 1899B to the Social Security Act that:

- Imposed new data reporting requirements for certain post-acute care (PAC) providers, including SNFs
- Required that the Centers for Medicare & Medicaid Services (CMS) implement a SNF quality reporting program (QRP).

As defined in the Social Security Act (Section 1899B(a)(2)(E)), for FYs beginning on or after the specified application date, the Social Security Act (Section 1888(e)(6)(B)(i)(II)) requires that each SNF submit (in a manner and within the time frames specified by CMS):

- Data on quality measures specified under the Social Security Act (Section 1899B(c)(1))
- Data on resource use and other measures specified under the Social Security Act (Section 1899B(d)(1)).

Note that the SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities, and all non-critical access hospital swing-bed rural hospitals.

Beginning with FY 2018, and each subsequent year, if a SNF does not submit required quality data, their payment rates for the year are reduced by two percentage points for that fiscal year. Application of the two percentage reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. In addition, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

CR 9944 revises Chapter 3, Section 80 of the *Medicare Quality Reporting Incentive Programs Manual* to reflect changes to the payment reduction reconsideration process. The revised manual section is included with CR 9944.

Your MAC will notify you by letter if your SNF was non-compliant with the QRP requirements and are, therefore, subject to the payment reduction.

Additional information

The official instruction, CR 9944, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R67QRI.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
July 17, 2017	Initial article released.

MLN Matters® Number: MM9944
Related Change Request (CR) #: CR 9944
Related CR Release Date: July 14, 2017
Effective Date: August 14, 2017
Related CR Transmittal #: R67QRI
Implementation Date: August 14, 2017

SSI/Medicare beneficiary data for FY 2015 for IPPS hospitals, IRFs, and LTCH

Provider types affected

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

Provider action needed

Change request (CR) 10026 informs MACs about updated data for determining the disproportionate share adjustment for inpatient prospective payment system (IPPS) hospitals and the low income patient (LIP) adjustment for IRFs as well as payments as applicable for long term care hospitals (LTCH) discharges (for example, discharges paid the IPPS comparable amount under the short-stay outlier payment adjustment). Make sure that your billing staffs are aware of these changes.

Background

The SSI/Medicare beneficiary data for hospitals are available electronically and contains the name of the hospital, Centers for Medicare & Medicaid Services (CMS) certification number, supplemental security income (SSI) days, total Medicare days, and the ratio of days for patients entitled to Medicare Part A attributable to SSI recipients. The files are available at the following as follows:

- IPPS hospitals: *https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/dsh.html*
- IRFs: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html*
- Long term care hospitals (LTCHs): *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html*

The data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during fiscal year (FY) 2015 (cost reporting periods beginning on or after October 1, 2014, and before October 1, 2015), except as explicitly directed otherwise by the Centers for Medicare & Medicaid Services (CMS).

These instructions also provide guidance for accepting FY 2015 amended cost reports from hospitals requesting to revise worksheet S-10 (cost reports starting on or after October 1, 2014, and prior to October 1, 2015) in light of CMS's proposal to begin using worksheet S-10 data to determine uncompensated care payments starting in FY 2019. For revisions to be considered, hospitals must submit their amended cost report containing the revised worksheet S-10 (or a completed worksheet S-10 if no data had been included on the previously submitted cost report) no later than September 30, 2017. CMS notes that the amended cost report must be received by the MAC by September 30, 2017. Submissions received on or after October 1, 2017, will not be accepted.

Providers should follow the current requirements for electronic submission of cost reports found at 42 CFR §413.24(f)(4), which specify "a provider must submit a hard copy of a settlement summary, a statement of certain worksheet totals found within the electronic file, and a statement signed by its administrator or chief financial officer certifying the accuracy of the electronic file or the manually prepared cost report." (See 42 CFR §413.24(f)(4)(iv).) This instruction applies only to worksheet S-10 of FY 2015 cost reports for IPPS hospitals. Revisions to worksheet S-10 from other FYs, revisions to other worksheets of the FY 2015 cost reports, or revisions to worksheet S-10 by non-IPPS hospitals are not subject to this instruction.

If ab IPPS hospital whose FY 2015 cost report has been final settled requests to revise Worksheet S-10 for that FY 2015 cost report and the request is received by the MAC on or before September 30, 2017, MACs will issue a /notice of Reopening in order to accept the revisions to or newly submitted Worksheet S-10 and issue a revised notice of program reimbursement on or before October 31, 2017.

Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that for discharges occurring on or after May 1, 1986, an additional payment must be made to IPPS hospitals serving a disproportionate share of low income patients. The additional payment is determined by multiplying the federal portion of the diagnosis-related group (DRG) payment by the disproportionate share hospital (DSH) adjustment factor, and beginning for discharges occurring on or after October 1, 2014, the additional payment is determined by multiplying the DRG payment by the DSH adjustment factor reduced by 75 percent. (See *42 CFR 412.106*.) Under the IRF prospective payment system (PPS), IRFs receive an additional payment amount to account for the cost of furnishing care to low income patients. The additional payment is determined by multiplying the federal prospective payment by the LIP adjustment formula. (See *42 CFR 412.624(e)(2)*.)

Under the LTCH PPS, the payment adjustment for short-stay outlier (SSO) cases at 42 CFR 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (that is, the "IPPS comparable amount."). This calculation includes an "IPPS Comparable" DSH adjustment, where applicable, that is determined using the best available SSI data at the time of claim payment (See *42 CFR 412.529(d)(4)*).

Additional information

The official instruction, CR 10026, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1863OTN.pdf*.

42 CFR 412.106 is available at *https://www.gpo.gov/fdsys/*

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DMEPOS: Payment for accessories used with group 3 complex rehabilitative power wheelchairs effective July 1

The Centers for Medicare & Medicaid Services is adopting a new interpretation of the statute that impacts how adjustments to the fee schedule based on information from competitive bidding programs apply to wheelchair accessories used with group three complex rehabilitative power wheelchairs. Effective July 1, fee schedule amounts for wheelchair accessories and back and seat cushions used with group three complex rehabilitative power wheelchairs will not be adjusted using information from the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. The fee schedule amounts will be based on the unadjusted fee schedule amounts updated by the annual fee schedule covered item update. Suppliers should continue to use the KU modifier when billing for wheelchair accessories and seat and back cushions furnished in connection with group three complex rehabilitative power wheelchairs with dates of service beginning July 1, 2017.

For more information, view the posting and *FAQ* on the *DME Center* web page.

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pkg/CFR-2013-title42-vol2/pdf/CFR-2013-title42-vol2-sec412-106.pdf.

42 CFR 412.624(e)(2) is available at *https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec412-624.pdf*.

42 CFR 412.529(d)(4) is available at *https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec412-529.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
July 3, 2017	Initial article released

MLN Matters® Number: MM10026
Related CR Release Date: June 30, 2017
Related CR Transmittal Number: R1863OTN
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Screening for hepatitis B virus infection

***Note**: This article was revised June 30, 2017, to reflect an updated change request (CR) 9859. In the article, the CR release date, transmittal numbers, and the Web address of the CR are revised. All other information is unchanged. This information was previously published in the June 2017 Medicare A Connection, pages 33-37.*

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

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, ≥ two percent), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥ eight percent), 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 (HBs Ag) 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 claims 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

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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, 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 therevenue 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 submitted 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

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Code	Description
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
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."

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- 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

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).
- 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

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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/R3804CP.pdf*. The second transmittal updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R198NCD.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
June 30, 2017	This article was revised to reflect an updated CR 9859. In the article, the CR release date, transmittal numbers, and the web address of the CR are revised. All other information is unchanged.
June 9, 2017	The article was revised to reflect an updated CR that changed the implementation date from January 1, 2018, to January 2, 2018.
May 4, 2017	Initial article released.

MLN Matters® Number: MM9859 *Revised*
Related Change Request (CR) #: CR 9859
Related CR Release Date: June 29, 2017
Effective Date: September 28, 2016
Related CR Transmittal #: R3804CP and R198NCD
Implementation Date: January 2, 2018

Quarterly provider update

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

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

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

Upcoming provider outreach and educational events

Diabetic shoes – An A/B MAC and DME MAC collaboration webinar

Date: Wednesday, August 16
Time: 12:30-2 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0381841.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 June 29, 2017

MLN Connects® for June 29, 2017
View this edition as a PDF

News & Announcements

- New Medicare Number: Prepare Your Systems for April 2018
- DMEPOS: Payment for Group 3 Complex Rehabilitative Power Wheelchair Accessories Effective July 1
- Quarterly Provider Update

Provider Compliance

- Evaluation and Management: Correct Coding

Upcoming Events

- Quality Payment Program Year 2 Proposed Rule Listening Session – July 5
- DMEPOS Prior Authorization Special Open Door Forum – July 6
- ESRD QIP: Reviewing Your Facility's PY 2018 Performance Data – July 10
- Creating and Verifying Your National Provider Identifier Call – July 12

Medicare Learning Network Publications & Multimedia

- Behavioral Health Integration Services Fact Sheet – New
- Evaluation and Management Services Web-Based Training Course – New
- Dementia Care Call: Audio Recording and Transcript – New
- Medical Privacy of Protected Health Information Fact Sheet – Revised
- Medicare Basics: Commonly Used Acronyms Educational Tool – Revised

SPECIAL

from front page

Physician Fee Schedule: CMS Proposes 2018 Payment and Policy Updates

Proposed rule & Request for Information provide flexibility, support strong patient-doctor relationships

On July 13, CMS issued a proposed rule that would update Medicare payment and policies for doctors and other clinicians who treat Medicare patients in CY 2018. The proposed rule is one of several Medicare payment rules for CY 2018 that reflects a broader strategy to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.

The Physician Fee Schedule is updated annually to include changes to payment policies, payment rates, and quality provisions for services furnished to Medicare beneficiaries. This proposed rule would provide greater potential for payment system modernization and seeks public comment on reducing administrative burdens for providing patient care, including visits, care management, and telehealth services. The rule takes steps to better align incentives and provide clinicians with a smoother transition to the new Merit-based Incentive Payment System under the Quality Payment Program. The rule encourages fairer competition between hospitals and physician practices by promoting greater payment alignment, and it would improve the payment for office-based behavioral health services that are often the therapy and counseling services used to treat opioid addiction and other substance use disorders. In addition, the proposed rule makes additional proposals to implement the Center for Medicare and Medicaid Innovation's Medicare Diabetes Prevention Program expanded model starting in 2018.

For More Information:

- *Proposed Rule*
- *Fact Sheet*

See the full text of this excerpted *Press Release* (issued July 13).

MLN Connects® for July 6, 2017

MLN Connects® for July 6, 2017

View this edition as a PDF

News & Announcements

- ESRD: Proposed 2018 Policy and Payment Rate Changes
- ESRD QIP: Prepare for the PY 2018 Preview Period
- QPP: New Resources to Help Clinicians Participate in MIPS
- QPP: New Webpage for Clinicians in Small, Rural, or Underserved Areas
- Open Payments Program Posts 2016 Financial Data

Provider Compliance

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

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2018 Performance Data Call – July 10
- Creating and Verifying Your National Provider Identifier Call – July 12
- Assessing Your Ability to Support Patient Self-Management Webinar – July 19
- ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session – July 26

Medicare Learning Network Publications & Multimedia

- Modernized National Plan and Provider Enumeration System MLN Matters Article – New
- Infection Control: Hand Hygiene Video – New
- PECOS for Provider and Supplier Organizations Booklet – Reminder
- Medicare Vision Services Fact Sheet – Reminder
- Mass Immunizers and Roster Billing Booklet – Reminder

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MLN Connects® for July 13, 2017

MLN Connects® for July 13, 2017

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News & Announcements

- New Medicare Cards with New Numbers: 3 Changes You May Need to Make
- QRDA III Implementation Guide Available
- Quality Payment Program: View Recent Webinar Recordings
- Hospital Discharge Notices
- IPPS Hospitals: FY 2014 S-10 Revisions
- Recognizing National HIV Testing Day

Provider Compliance

- OIG Video: Reporting Fraud to the Office of the Inspector General

Claims, Pricers & Codes

- ICD-10-CM Errata Available

Upcoming Events

- Revised Interpretive Guidance for Nursing Homes and New Survey Process Call – July 25
- ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session – July 26
- IRF Quality Reporting Program Refresher Training Webinar – August 15
- Comparative Billing Report on Drugs of Abuse Testing Webinar – August 23

Medicare Learning Network Publications & Multimedia

- CLIA Webcast: Audio Recording and Transcript – New
- Appeals Call: Audio Recording and Transcript – New
- Acute Care Hospital Inpatient Prospective Payment System Booklet – Reminder
- Skilled Nursing Facility Prospective Payment System Booklet – Reminder
- Ambulatory Surgical Center Fee Schedule Fact Sheet – Reminder
- Ambulance Fee Schedule Fact Sheet – Reminder
- Health Professional Shortage Area Physician Bonus Program Fact Sheet – Reminder
- Suite of Products & Resources for Billers & Coders Educational Tool – Reminder

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MLN Connects® for July 20, 2017

MLN Connects® for July 20, 2017

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News & Announcements

- Home Health Agency CoP Final Rule: Effective Date Extended to January 13, 2018
- Hospice Quality Reporting Program: Non-Compliance Letters
- IRF Quality Reporting Program: Non-Compliance Letters
- LTCH Quality Reporting Program: Non-Compliance Letters
- SNF Quality Reporting Program: Non-Compliance Letters
- IRF, LTCH, and SNF Quality Reporting Program Data due August 15
- New PEPPER Available for Home Health Agencies and Partial Hospitalization Programs
- Hospitals: 2018 QRDA Category I Implementation Guide
- Health Care Fraud Takedown: Charges Against Individuals Responsible for $1.3 Billion in Fraud

Provider Compliance

- Billing For Stem Cell Transplants

Claims, Pricers & Codes

- Clinicians: Medicare Part B Crossover Claims Issue Tied to Error Code H31312

Upcoming Events

- Revised Interpretive Guidance for Nursing Homes and New Survey Process Call — July 25
- ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session — July 26
- New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments - Listening Session — August 1

- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health Quality Reporting Program Call — August 17
- LTCH Quality Reporting Program Refresher Training Webinar — August 22

Medicare Learning Network Publications & Multimedia

- Quality Payment Program Listening Session: Audio Recording and Transcript — New
- Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 4] Educational Tool — New
- Medicare Basics: Parts A and B Claims Overview Video — Reminder
- Chronic Care Management Services Fact Sheet — Reminder
- Suite of Products & Resources for Billers & Coders Educational Tool – Reminder

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

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