# Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

*A Newsletter for MAC Jurisdiction N Providers*

August 2017


## In this issue



# Suppression of the SPR in 45 days if also receiving electronic remittance advice

## Provider types affected

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

## Provider action needed

Change request (CR) 10151 provides notice that beginning January 2, 2018, Medicare's shared system maintainers (SSMs) must eliminate issuance of standard paper remittance advice (SPRs) to those providers/suppliers (or a billing agent, clearinghouse, or other entity representing those providers/suppliers) who also have been receiving electronic remittance advice (ERA) transactions for 45 days or more. The shared system changes to suppress the distribution of SPRs were implemented in January 2006 per CR 3991 (issued August 12, 2005, Transmittal 645). Make sure your billing staffs are aware of the suppression of the SPR.

## Background

The SPR is the hard copy version of an ERA. MACs, including durable medical equipment (DME) MACs must be capable of producing SPRs for providers/suppliers who are unable or choose not to receive an ERA. The MACs and the DME MACs suppress distribution of SPRs if an electronic data interchange (EDI) enrolled provider/supplier is also receiving ERAs for more than 31 days for institutional health care claims (837I) and 45 days for DME and professional health care claims (837P). Internet-only-manuals (IOMs), *MLN Matters*® article MM4376 provided information to the MACs regarding the receipt of SPR and ERA distribution time lines.

Beginning February 14, 2018, the SSMs shall suppress the delivery of SPR to the MACs EDI enrolled providers/suppliers who are also receiving both the ERA and SPR. In rare situations (such as natural or man-made disasters) exceptions to this policy may be allowed at the discretion of the Centers for Medicare & Medicaid Services (CMS).

See **ERA**, page 4

# Contents




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

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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

# Claims returned to provider (RTP) with reason code 34932

### Issue

Claims that were worked out of suspense for reason code 32103 are now RTPing with reason code 34932.

### Resolution

Claims will go to status location SB9000 once the appropriate End POA ind has been added.

### Status/date resolved

Closed

### Provider action

Providers whose claims were RTPed with reason code 34932 may resubmit (PF9) those affected claims with the appropriate End POA Ind.


### Current processing issues

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

# Part A processing issues from IOCE errors for OPPS claims

### Issue

Issues with outpatient prospective payment system (OPPS) services due to integrated outpatient code editor (IOCE) logic errors.

### Resolution

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

### Status/date resolved

Closed/All impacted claims were adjusted by July 1.

### 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

**Logic 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.

General Information

# Provider-based determination checklists

## Provider types affected

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

## What you need to know

Change request (CR) 10095 advises MACs to use a uniform electronic provider-based (PB) checklist to perform uniform reviews of PB applications.

## Background

Prior to September 2014, the Centers for Medicare & Medicaid Services (CMS) had been receiving discrete, PB checklists from each of the MACs and found that each one was significantly different from the next. Some checklists were incomplete and did not cover all the required information from the PB regulations. Some checklists did not include sufficient information. CR 10095 instructs MACs to use the comprehensive electronic PB checklist when reviewing PB attestations.

CR 10095 does not make any policy revisions to the review of PB applications. Some checklists were incomplete, did not cover all the required information from the PB regulations, and/or did not include sufficient information.

## Additional information

The official instruction, CR 10095, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2017Downloads/R1891OTN.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/MonitoringPrograms/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

## Document history

| Date of change | Description |
|---|---|
| August 4, 2017 | Initial article released |

*MLN Matters*® Number: MM10095
Related Change Request (CR) Number: CR 10095
Related CR Release Date: August 4, 2017
Effective Date: November 6, 2017
Related CR Transmittal Number: R1891OTN
Implementation Date: November 6, 2017



# ERA

From front page

MACs will not send a SPR/hard copy version to a particular provider/supplier unless this requirement causes hardship and CMS has approved a waiver requested by your MAC.

**Note**: MM4376 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4376.pdf*.

## Additional information

The official instruction, CR 10151, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1890OTN.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 |
|---|---|
| August 7, 2017 | Initial article released. |

*MLN Matters*® Number: MM10151
Related CR Release Date: August 4, 2017
Related CR Transmittal Number: R1890OTN
Related Change Request (CR) Number: 10151
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

# Modify CWF provider queries to only accept NPI as valid provider number

## Provider type affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers querying Medicare's common working file (CWF) for checking eligibility and entitlement status for Medicare beneficiaries.

## Provider action needed

This article is based on change request (CR) 10098, which informs the MACs about modifications to the CWF provider queries, ELGA, ELGH, HIQA, HIQH, and HUQA, to only accept the national provider identifier (NPI) as a valid provider number. Make sure that your billing staffs are aware of these changes.

## Background

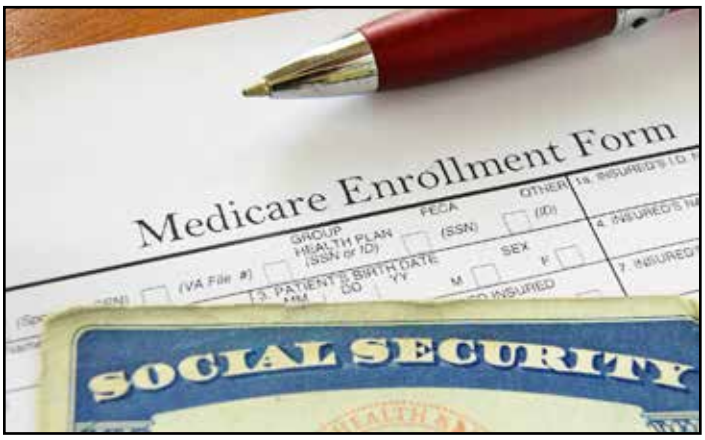
Providers, clearinghouses, and/or third-party vendors, herein referred to as "trading partners," verify an individual's Medicare eligibility and entitlement status prior to and/or while the individual is receiving services before billing Medicare for services rendered to Medicare beneficiaries using HIPAA eligibility transaction system (HETS) and/or CWF.

Within CWF, trading partners use CWF provider queries, ELGA, ELGH, HIQA, HIQH, and HUQA. Currently, trading partners are allowed to use either legacy provider numbers (CMS certification number (CCN) or unique physician identification number (UPIN)) or NPI on CWF provider queries.

The Centers for Medicare & Medicaid Services (CMS) is requiring CWF to modify CWF provider queries to only accept NPI as a valid provider number.

## Additional information

The official instruction, CR 10098, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1877OTN.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 28, 2017 | Initial article released. |

*MLN Matters*® Number: MM10098
Related CR Release Date: July 27, 2017
Related CR Transmittal Number: R1877OTN
Related Change Request (CR) Number: CR10098
Effective Date: January 1, 2018
Implementation Date: January 2, 2018



# CMS National Provider Enrollment Conference – September 6-7, 2017

**North Charleston, South Carolina**

**Wednesday, September 6, 2017, from 8 a.m.- 5 p.m. ET**
**Thursday, September 7, 2017, from 8 a.m.- 4 p.m. ET**

The Centers for Medicare & Medicaid Services (CMS) will hold a National Provider Enrollment Conference September 6-7, 2017, at the Charleston Area Convention Center in South Carolina. Take advantage of this opportunity to interact directly with CMS and Medicare administrative contractor provider enrollment experts.

Register at *https://www.palmgba.com/events/NPEC2017/* and learn more about this conference.

# NGACO year three benefit enhancements

## Provider types affected

This *MLN Matters*® article is intended for providers who are participating in next generation accountable care organizations (NGACOs) and submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

## Provider action needed

Change request (CR) 10044 provides instruction to MACs to implement two new benefit enhancements for performance year three (2018) of the NGACO model. MACs will process and pay claims for asynchronous telehealth and post-discharge home visit waiver services when those services meet the appropriate payment requirements as outlined in CR 10044. Make sure your billing staff is aware of these changes.

## Background

The aim of the NGACO model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare fee-for-service (FFS) through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, the Centers for Medicare & Medicaid Services (CMS) is issuing the authority under Section 1115A of the Social Security Act (the Act) (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO model.

### Asynchronous telehealth

CMS is expanding the current telehealth waiver to include asynchronous (also known as “storeand-forward”) telehealth in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients’ condition and adequate for rendering or confirming a diagnosis or treatment plan.

Payment will be permitted for telemedicine when asynchronous telehealth in single or multimedia formats, is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology services. Distant-site practitioners will bill for these new services using new codes, and the distant site practitioner must be an NGACO participant or preferred provider.

### Asynchronous telehealth based on intra-service + five minutes post-service time

- **Code 1:** G9868– Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, less than 10 minutes.
- **Code 2:** G9869– Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, 10-20 minutes.
- **Code 3**: G9870 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, 20 or more minutes.

## Additional information

The official instruction, CR 10044, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R177DEMO.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/MonitoringPrograms/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

## Document history

| Date of change | Description |
|---|---|
| August 4, 2017 | Initial article released |

*MLN Matters*® Number: MM10044
Related Change Request (CR) Number: 10044
Related CR Release Date: August 4, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R177DEMO
Implementation Date: January 2, 2018

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

***Note:*** *This article was revised July 24, 2017, to add links to related MLN Matters® articles. SE1128 reminds all Medicare providers that they may not bill beneficiaries enrolled in the qualified Medicare beneficiary (QMB) program for Medicare cost-sharing. MM9817 states that change request (CR) 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing. All other information remains the same.This information was previously published in the July 2017 Medicare A Connection, pages 3-4.*

## 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 claim processing systems to help providers more readily identify the 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 claims 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 fee-for-service (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 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.

See **QMB**, next page

# QMB

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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

| Date of change | Description |
|---|---|
| July 24, 2017 | The article was revised to add links to related *MLN Matters*® articles. *SE1128* reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. *MM9817* states that CR 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing |

| Date of change | Description |
|---|---|
| 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. |
| 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. |
| February 3, 2017 | Initial article released |

*MLN Matters*® Number: MM9911
Related CR Release Date: June 28, 2017
Related CR Transmittal Number: R3802CP
Related Change Request (CR) Number: CR 9911
Effective Date: For claims processed on or after October 2, 2017
Implementation Date: October 2, 2017

This section of *Medicare A 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 *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 *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 search capability simplifies LCD lookup

Providers in need of a quick and direct method to locate local coverage determinations (LCDs) by procedure code now have a simple way to do so by using First Coast Service Options' website search functionality.

Providers can now simply enter a procedure code, keyword, or ICD-10 code into the website search bar and search "LCDs only" to find the matching results. This search function replaces the multiple steps currently required by other methods, and lets providers locate the corresponding LCDs by using First Coast's own LCD data.

*Click here for more information.*

## Retired LCDs

# Intraoperative neurophysiology monitoring – retired Part A and Part B LCD

### LCD ID number: L33379 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the intraoperative neurophysiology monitoring local coverage determination (LCD), it was determined that this LCD and "coding guideline" attachment are no longer required and, therefore, are being retired.

### Effective date

The retirement of this LCD and "coding guideline" attachment is effective for services rendered **on or after August 11, 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*.

# Low density lipoprotein (LDL) apheresis – retired Part A and Part B LCD

### LCD ID number: L33381 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the low density lipoprotein (LDL) apheresis 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 August 11, 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*.

# New advance beneficiary notice required for use by August 21

The Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to original Medicare (fee-for-service) beneficiaries in situations where Medicare payment is expected to be denied. The Centers for Medicare & Medicaid Services (CMS) has issued a revised ABN that includes an expiration date; there are no additional changes. The old forms were acceptable until June 21, 2017, at which time the renewed form became mandatory for use. CMS allowed a 60-day transition period for the renewed forms, thus use of the new form is required as of August 21, 2017.

More information may be found at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html*. The new forms may be downloaded at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Forms-English-and-Spanish.zip*.

# Transitional drug add-on payment adjustment for ESRD drugs

## Provider types affected

This *MLN Matters*® article is intended for end-stage renal disease (ESRD) facilities submitting claims to Medicare administrative contractors (MACs) for certain ESRD drugs provided to Medicare beneficiaries.

## Provider action needed

This article informs you about change request (CR) 10065, which directs the MACS to implement the transitional drug add-on payment adjustment (TDAPA). Please be sure your billing staffs are informed of this change.

## Background

In accordance with section 217(c) of the Protecting Access to Medicare Act, the Centers for Medicare & Medicaid Services (CMS) implemented a drug designation process for: (1) determining when a product is no longer an oral-only drug; and (2) including new injectable and intravenous products into the ESRD prospective payment system (PPS). Under the drug designation process, CMS provides payment using a TDAPA for new injectable or intravenous drugs and biologicals that qualify under 42 *Code of Federal Regulations* (CFR) 413.234(c)(1).

To be considered a new injectable or intravenous product, the drug should be approved by the Food and Drug Administration (FDA), commercially available, assigned a Healthcare Common Procedure Coding System (HCPCS) code, and designated by CMS as a renal dialysis service. CMS considers the new injectable or intravenous drug to be included in the ESRD PPS bundled payment (with no separate payment available) if used to treat or manage a condition for which there is an ESRD PPS functional category. CMS will pay for the drug or biological using a transitional drug add-on payment adjustment, if the new injectable or intravenous drug or biological is used to treat or manage a condition for which there is not an existing ESRD PPS functional category. While calcimimetics are included in the bone and mineral metabolism ESRD PPS functional category, they are an exception to the drug designation process as discussed in the Calendar Year (CY) 2016 ESRD PPS final rule (80 FR 69027). CMS bases the TDAPA on payment methodologies under section 1847A of the Social Security Act which are discussed in the *Medicare Claims Processing Manual*, Chapter 17, Section 20. This payment is applicable for a period of two years. While the TDAPA applies to a new injectable or intravenous drug or biological, the drug or biological is not considered an outlier service.

The ESRD PPS includes consolidated billing (CB) requirements for limited Part B services included in the ESRD facility's bundled payment. CMS periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

### Transitional drug add-on payment adjustment

Effective January 1, 2018, injectable, intravenous, and oral calcimimetics qualify for the TDAPA. ESRD facilities should report the AX modifier (Item furnished in conjunction with dialysis services) with the HCPCS for these drugs and biologicals to receive payment for these drugs using the TDAPA. While these drugs are eligible for the TDAPA, they do not qualify toward outlier calculation. Currently, calcimimetics are the only drug class that qualifies for payment using the TDAPA. **ESRD facilities should not use the AX modifier for any other drug until notified by CMS**.

Effective January 1, 2018, MACs will return to provider (RTP) ESRD claims (TOB 72x) when:

- HCPCS code J0604 or J0606 is present without modifier AX or
- Modifier AX is present without HCPCS code J0604 or J0606

J0604 and J0606 are drugs that are used for bone and mineral metabolism. Bone and mineral metabolism is an ESRD PPS functional category where drugs and biologicals that fall in this category are always considered to be used for the treatment of ESRD.

ESRD facilities will not receive separate payment for J0604 and J0606 with or without the AY modifier and the MACs will process the line item as covered with no separate payment under the ESRD PPS. The ESRD PPS CB requirements will be updated to include J0604 and J0606.

CR 10065 also implements the payer only value code Q8 (total TDAPA amount), to be used to capture the add-on payment. CR 10065 has an example of the calculation used in PRICER.

## Additional information

The official instruction, CR 10065, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1889OTN.pdf*.

The 2016 ESRD PPS final rule is available at *https://www.gpo.gov/fdsys/pkg/FR-2015-11-06/pdf/2015-27928.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 |
|---|---|
| August 9, 2017 | Initial article released |

*MLN Matters*® Number: MM10065
Related CR Release Date: August 4, 2017
Related CR Transmittal Number: R1889OTN
Related Change Request (CR) Number: CR 10065
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

# October update to 2017 codes used for SNF consolidated billing enforcement

## Provider types affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare administrative contractors (MACs), including durable medical equipment MACs (DME MACs), for services provided in a skilled nursing facility (SNF) to Medicare beneficiaries.

## Provider action needed

Change request (CR) 10163 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing (CB) provision of the SNF prospective payment system (PPS). The CR corrects an error impacting certain claims with dates of service on or after January 1, 2015, that Medicare mistakenly denied rejected prior to implementation of CR 10163. Make sure your billing staffs are aware of these changes.

## Background

CR 10163 alerts providers that the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to MACs will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB. The updated lists for institutional and professional billing are available at *https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*.

Certain radiation therapy codes are included as services that are not subject to SNF CB. These codes can be submitted globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC).

When the codes listed below are submitted globally or just for the technical component, the claims are being rejected by Medicare's common working file (CWF). That is to say, they are not allowed to pay separately outside of the consolidated payment that is made to the SNF.

When submitted with the 26 modifier for just the professional component, the claims have been allowed to pay. The following are the allowable HCPCS codes: 77014, 77750, 77761, 77762, 77763, 77776, 77777, 77778, 77785, 77786, 77787, 77789, 77790, 77799, 79005, 79101, and 79445.

This error is occurring because the codes were not added by CMS to the appropriate coding lists with the 2015, 2016, and 2017 SNF CB annual updates. CR 10163 corrects this error. Therefore, when brought to their attention, your MAC will reprocess claims with dates of service on or after January 1, 2015, that were erroneously denied/rejected.

## Additional information

The official instruction issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2017Downloads/R3825CP.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/MonitoringPrograms/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

## Document history

| Date of change | Description |
|---|---|
| August 4, 2017 | Initial article released |

*MLN Matters*® Number: MM10163
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Related CR Release Date: August 4, 2017
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Related CR Transmittal Number: R3825CP
Implementation Date: October 2, 2017

# MLN Connects® special edition – August 2, 2017

In this edition:

- CMS Finalizes 2018 Payment and Policy Updates for Medicare Hospital Admissions
- Inpatient Psychiatric Facilities: FY 2018 Medicare Payment and Policy Updates
- CMS Updates Medicare Payment Rates, Quality Reporting Requirements

## CMS Finalizes 2018 Payment and Policy Updates for Medicare Hospital Admissions

On August 2, CMS issued the FY 2018 Medicare Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule, which updates 2018 Medicare payment and policies when patients are discharged from hospitals. The final rule relieves regulatory burdens for providers, supports the patient-doctor relationship in healthcare, and promotes transparency, flexibility, and innovation in the delivery of care for Medicare patients.

"This final rule will help provide flexibility for acute and long-term care hospitals as they care for Medicare's sickest patients," said CMS Administrator Seema Verma. "Burden reduction and payment rate increases for acute care hospitals and long-term care hospitals will help ensure those suffering from severe injuries and illnesses have access to the care they need."

Due to the combination of payment rate increases and other policies and payment adjustments, particularly in changes in uncompensated care payments, acute care hospitals will see a total increase in Medicare spending on inpatient hospital payments of $2.4 billion in FY 2018. Based in part on the changes included in the final rule, overall payments to long-term care hospitals will decrease by $110 million in FY 2018.

In addition to the payment and policy updates for Medicare hospital admissions, the final rule addresses changes to how the public is notified of Medicare terminations of certain providers and implements the statutory extension of the Rural Community Hospital Demonstration.

For More Information:

*Final Rule*

*Fact Sheet*

See the full text of this excerpted *Press Release* (issued August 2).

## Inpatient Psychiatric Facilities: FY 2018 Medicare Payment and Policy Updates

On August 2, CMS issued a notice with comment period updating FY 2018 Medicare payment policies and rates for the Inpatient Psychiatric Facilities (IPF) Prospective Payment System. CMS estimates IPF payments to increase by 0.99 percent or $45 million in FY 2018. This amount reflects a 2.6 percent IPF market basket update less the productivity adjustment of 0.6 percentage point and less the 0.75 percentage point reduction required by law, for a net market basket update of 1.25 percent. Additionally, estimated payments to IPFs are reduced by 0.26 percentage point due to updating the outlier fixed-dollar loss threshold amount. CMS is also updating the IPF wage index for FY 2018.

CMS is soliciting comments on improvements that can be made to the healthcare delivery system that would reduce unnecessary burden for clinicians, providers such as IPFs, and patients and their families.

For more information, view the *notice with comment period*. See the full text of this excerpted *Fact Sheet* (issued August 2).

## CMS Updates Medicare Payment Rates, Quality Reporting Requirements

CMS issued three final rules outlining 2018 Medicare payment rates for skilled nursing facilities, hospice, and inpatient rehabilitation facilities. The final rules are effective for FY 2018 and reflect a broader Administration strategy to streamline administrative requirements for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.

"These announcements take important steps to support innovation in the delivery of care in order to promote a Medicare program that is responsive to patients' unique needs and ensure that patients have access to high-quality skilled nursing, hospice, and inpatient rehabilitative care," said CMS Administrator Seema Verma. "These rules update quality reporting requirements and allow providers to spend less time and fewer resources on cumbersome paperwork, so they can increase their focus on the needs of Medicare patients."

Final Rules:

- Hospice: *Fact Sheet* and *Final Rule*
- IRF: *Fact Sheet* and *Final Rule*
- SNF: *Fact Sheet* and *Final Rule*

See the full text of this excerpted *Press Release* (issued August 1).

# Fiscal year 2017 inpatient prospective payment system and long-term care hospital PPS changes

***Note**: This article was revised August 11, 2017, to reflect a revised change request (CR) 9723 issued August 9, 2017. In the CR, the out migration values in attachment 7 of the CR were revised. 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. This information was previously published in the November 2016 Medicare A Connection, pages 24-29.*

## Provider types affected

This *MLN Matters*® article is intended for hospitals that submit claims to Medicare administrative contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries by short-term acute care and long-term care hospitals (LTCHs).

## Provider action needed

This article is based on CR 9723 which implements policy changes for fiscal (FY) 2017 IPPS and LTCH PPS and covers services effective for hospital discharges occurring on or after October 1, 2016, through September 30, 2017, unless otherwise noted. Failure to adhere to these new policies could affect payment of Medicare claims. Make sure that your billing staff is aware of these IPPS and LTCH PPS changes for FY 2017.

## Background

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a prospective payment system (PPS) for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002. The Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually.

CMS displayed the following policy changes for FY 2017 in the *Federal Register* August 2, 2016, with a publication date of August 22, 2016. All items covered in CR 9723 are effective for hospital discharges occurring on or after October 1, 2016, through September 30, 2017, unless otherwise noted.

## IPPS FY 2017 update

### FY 2017 IPPS rates and factors

**Table 1--FY 2017 IPPS rates and factors**

| Factors | Rate |
|---|---|
| Standardized amount applicable percentage increase | ▪ 1.0165 if quality = '1' and EHR = 'blank' in provider specific file (PSF); or<br>▪ 1.00975 if quality = '0'and EHR = 'blank' in PSF; or<br>▪ 0.99625 if quality = '1'and EHR = 'Y' in PSF; or<br>▪ 0.9895 if quality = '0'and EHR = 'Y' in PSF |
| Common fixed loss cost outlier threshold | $23,573 |
| Federal capital rate | $446.79 |

**Operating rates for wage index > 1**

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**Operating rates for wage index < or = 1**

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### MS-DRG grouper and Medicare code editor changes

For discharges occurring on or after October 1, 2016, the fiscal intermediary shared system (FISS) calls the appropriate GROUPER based on discharge date. For discharges occurring on or after October 1, 2016, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors should have received the MCE documentation in August 2016. Note that the MCE version continues to match the grouper version.

Effective October 1, 2016, MS-DRGs 228 through 230 (Other cardiothoracic procedures w MCC, w CC and w/o CC/MCC, respectively) are collapsed from three severity levels to two severity levels by deleting MS-DRG 230 and revising MS-DRG 229, as follows:

- MS-DRG 229 Other cardiothoracic procedures w/o MCC
- MS-DRG 230 Other cardiothoracic procedures w/o CC/MCC

Effective October 1, 2016, the title for MS-DRG 884 (Organic disturbance and mental retardation) is revised to MS-DRG 884 (Organic disturbances and intellectual disability).

### Post-acute transfer and special payment policy

No new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy. See Table 5 of the FY 2017 IPPS/LTCH PPS final rule for a listing of all post-acute and special post-acute MS-DRGs at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*. Then click on the link on the left side of the

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screen titled, “FY 2017 IPPS Final Rule Home Page” or “Acute Inpatient Files for Download.”

### New technology add-on

The following items will continue to be eligible for new-technology add-on payments in FY 2017:

1. Name of approved new technology: CardioMEMS™ HF Monitoring System
   - Maximum add-on payment: $8,875
   - Identify and make new technology add-on payments with ICD-10-PCS procedure code 02HQ30Z or 02HR30Z
2. Name of approved new technology: Blinatumomab (BLINCYTO™)
   - Maximum add-on payment: $27,017.85
   - Identify and make new technology add-on payments with ICD 10 PCS procedure code XW03351 or XW04351
3. Name of approved new technology: LUTONIX® drug coated balloon (DCB) percutaneous transluminal angioplasty (PTA) and IN.PACT™Admiral™ pacliaxel coated percutaneous transluminal angioplasty (PTA) balloon catheter
   - Maximum add-on payment: $1,035.72
   - Identify and make new technology add-on payments with any of the following ICD-10-PCS procedure codes: 047K041, 047K0D1, 047K0Z1, 047K341, 047K3D1, 047K3Z1, 047K441, 047K4D1, 047K4Z1, 047L041, 047L0D1, 047L0Z1, 047L341, 047L3D1, 047L3Z1, 047L441, 047L4D1, 047L4Z1, 047M041, 047M0D1, 047M0Z1, 047M341, 047M3D1, 047M3Z1, 047M441, 047M4D1, 047M4Z1, 047N041, 047N0D1, 047N0Z1, 047N341, 047N3D1, 047N3Z1, 047N441,047N4D1, 047N4Z1

The following items will be eligible for new-technology add-on payments in FY 2017:

4. Name of approved new technology: MAGEC® Spinal Bracing Distraction system
   - Maximum add-on payment: $15,750
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes XNS0032, XNS0432, XNS3032, XNS3432, XNS4032, or XNS4432
5. Name of approved new technology: GORE IBE device system
   - Maximum add-on payment: $5,250
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 04VC0EZ; 04VC0FZ; 04VC3EZ; 04VC3FZ; 04VC4EZ; 04VC4FZ; 04VD0EZ; 04VD0FZ; 04VD3EZ; 04VD3FZ; 04VD4EZ; or 04VD4FZ
6. Name of approved new technology: Idarucizumab
   - Maximum add-on payment: $1,750
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03331 or XW04331
7. Name of approved new technology: Defitelio®
   - Maximum add-on payment: $75,900
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03392 and XW04392
8. Name of approved new technology: Vistogard™
   - Maximum add-on payment: $37,500
   - Identify and make new technology add-on payments with any of the following ICD-10-PCS diagnosis codes T45.1X1A, T45.1X1D, T45.1X1S, T45.1X5A, T45.1X5D, and T45.1X5S in combination with ICD-10-PCS procedure code XW0DX82

### Cost of living adjustment (COLA) update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2017, and are the same COLAs established for FY 2014. These COLAs are shown in the following table:

**Table 2: FY 2017 cost-of-living adjustment factors (COLAs): Alaska hospitals**

| Alaska | Cost of living adjustment factor |
|---|---|
| City of Anchorage and 80-kilometer (50-mile) radius by road | 1.23 |
| City of Fairbanks and 80-kilometer (50-mile) radius by road | 1.23 |
| City of Juneau and 80-kilometer (50-mile) radius by road | 1.23 |
| Rest of Alaska | 1.25 |

**Table 2: FY 2017 cost-of-living adjustment factors (COLAs): Hawaii hospitals**

| Hawaii | Cost of living adjustment factor |
|---|---|
| City and County of Honolulu | 1.25 |
| County of Hawaii | 1.19 |
| County of Kauai | 1.25 |
| County of Maui and County of Kalawao | 1.25 |

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## FY 2017 wage index changes and issues

**1. New wage index labor market areas and transitional wage indexes**

a. Effective October 1, 2014, CMS revised the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 census data.

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, for the few hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, under the new OMB delineations, CMS assigned a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for three years beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or redesignation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

Note that for hospitals that are receiving the three-year hold-harmless wage index, the transition is only for the purpose of the wage index and does not affect the hospital's urban or rural status for any other payment purposes.

b. As discussed in the FY 2017 IPPS/LTCH PPS final rule (*81 FR 56913*), among other changes, OMB Bulletin No. 15-01 made the following changes that are relevant to the IPPS wage index:

- Garfield County, OK, with principal city Enid, OK, which was a micropolitan geographically rural) area, now qualifies as an urban new CBSA 21420 called Enid, OK.

**2. Treatment of certain providers redesignated under the Social Security Act (Section 1886(d)(8)(B))**

*42 CFR 412.64(b)(3)(ii)* implements Section (1886(d)(8)(B)) of the Social Security Act which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as "Lugar counties".) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes.

**3. Section 505 hospitals (out-commuting adjustment)**

Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the "outmigration adjustment, is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare Geographic Classification Review Board (MGCRB), reclassified as a rural hospital under *§412.103*, or redesignated under the Social Security Act (Section 1886(d)(8)(B)).

## Treatment of certain urban hospitals reclassified as rural hospitals under § 412.103 and hospitals reclassified under the MGCRB

An urban hospital that reclassifies as a rural hospital under § 412.103 is considered rural for all IPPS purposes. Note, hospitals reclassified as rural under §412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see §412.320(a)(1)).

Prior to April 21, 2016, the regulations at § 412.230(a)(5)(ii) and §412.230(a)(5)(iii) prohibited hospitals from simultaneously receiving an urban to rural reclassification under §412.103 and a reclassification under the MGCRB. Also, the regulations did not allow a Lugar hospital (that is, a hospital located in a Lugar county) to keep its Lugar status if it was approved for an urban to rural reclassification under § 412.103. In light of court decisions that ruled as unlawful the regulation precluding a hospital from maintaining simultaneous MGCRB and § 412.103 reclassifications, on April 18, 2016, CMS issued an interim final rule with comment period (CMS-1664-IFC) amending the regulations to conform to the court decisions. The IFC is effective April 21, 2016, and was finalized in the *Federal Register* published August 2, 2016. The IFC allows hospitals nationwide that have an MGCRB reclassification or Lugar status during FY 2016 and subsequent years the opportunity to simultaneously seek urban to rural reclassification under §412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or Lugar status.

## Multi-campus hospitals with inpatient campuses in different CBSAs

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multi-campus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA. In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

## Medicare-dependent, small rural hospital (MDH) program expiration

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The MDH program is currently effective through September 30, 2017, as provided by Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015. Provider types 14 and 15 continue to be valid through September 30, 2017.

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In the 2016 OPPS final rule, CMS provided for a transition period for these hospitals to mitigate the financial impact of losing MDH status to hospitals that (1) lost their MDH status because they are no longer in a rural area due to the adoption of the new OMB delineations in FY 2015 and (2) have not reclassified from urban to rural under the regulations at §412.103 before January 1, 2016. During the transition period (January 1, 2016, through September 30, 2017), such hospitals ("qualifying former MDHs") will receive a transitional add-on payment. For discharges occurring on or after October 1, 2016, through September 30, 2017, qualifying former MDHs will receive an add-on payment equal to one-third of "the MDH add-on" (that is, one-third of 75 percent of the amount by which the federal rate payment is exceeded by the hospital's hospital-specific rate). Information on the requirements implementing this transitional add-on payment for former MDHs are in CR 9408, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3390CP.pdf*.

Based on the best available information, CMS has identified the hospitals it believes qualify for this transitional add-on payment. The Pricer logic has been modified to calculate this transitional add-on payment in the HSP-payment field in the Pricer for the qualifying hospitals identified by CMS.

### Hospital-specific (HSP) rate factors for sole-community hospitals (SCHs) and Medicare-dependent, small rural hospitals (MDHs)

For FY 2017, the HSP amount in the PSF for SCHs and MDHs will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480, the FY 2017 two-midnight rule one-time prospective increase of 1.006 (as well as the removal of 0.998 two-midnight rule adjustment applied in FY 2014), and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

### Low-volume hospitals – criteria and payment adjustments for FY 2017

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 204 of the Medicare Access and CHIP Reauthorization Act of 2015 extended the temporary changes to the low-volume hospital payment adjustment through September 30, 2017.

In order to qualify as a low-volume hospital in FY 2017, a hospital must be located more than 15 road miles from another "subsection (d) hospital" and have less than 1600 Medicare discharges (which includes Medicare Part C discharges and is based on the latest available MedPAR data). The applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges. For FY 2017, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2016 update of the FY 2015 MedPAR file. Table 14 of the FY 2017 IPPS/LTCH PPS final rule (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html*) lists the "subsection (d)" hospitals with fewer than 1,600 Medicare discharges based on the March 2016 update of the FY 2015 MedPAR file and their low-volume hospital payment adjustment for FY 2017 if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

A hospital must notify and provide documentation to its MAC that it meets the mileage criterion as outlined in prior program guidance and the FY 2017 IPPS/LTCH PPS final rule.

To receive a low-volume hospital payment adjustment under § 412.101 for FY 2017, a hospital must make a written request for low-volume hospital status that was received by its MAC no later than September 1, 2016, in order for the applicable low-volume hospital payment adjustment to be applied to payments for discharges occurring on or after October 1, 2016. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment in FY 2016 may continue to receive a low-volume hospital payment adjustment for FY 2017 without reapplying if it continues to meet the Medicare discharge criterion established for FY 2017 (as shown in Table 14 of the FY 2017 IPPS/LTCH PPS final rule) and the mileage criterion. However, the hospital must have send written verification that was received by its MAC no later than September 1, 2016, stating that it continues to be more than 15 miles from any other "subsection (d)" hospital. This written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. If a hospital's written request for low-volume hospital status for FY 2017 was received after September 1, 2016, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC shall apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2017 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

### Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at *www.qualitynet.org*.

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### Hospital acquired condition reduction program (HAC)

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. Under the HAC reduction program, a one (1) percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specified fiscal year.

A list of providers subject to the HAC reduction program for FY 2017 was not publicly available in the final rule because the review and correction process was not yet completed. Updated hospital level data for the HAC reduction program will be made publicly available following the review and corrections process.

### Hospital value-based purchasing

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the hospital value-based purchasing (VBP) program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. Under its current agreement with CMS, Maryland hospitals are not subject to the hospital VBP program for the FY 2017 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 *(§412.160* through *§412.162*).

For FY 2017 CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2017. CMS expects to post the value-based incentive payment adjustment factors for FY 2017 in the near future in *Table 16B of the FY 2017 IPPS/LTCH PPS final rule*.

### Hospital readmissions reduction program

The readmissions payment adjustment factors for FY 2017 are in *Table 15 of the FY 2017 IPPS/LTCH PPS final rule*. Hospitals that are not subject to a reduction under the hospital readmissions reduction program in FY 2017 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2017, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

**Note**: Hospitals located in Maryland (for FY 2017) and in Puerto Rico are not subject to the hospital readmissions reduction program, and therefore, are not listed in Table 15.

### Medicare disproportionate share hospitals (DSH) program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014, by providing that hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital' s share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare supplemental security income (SSI) days and Medicaid days, relative to all Medicare DSH hospitals' insured low income days.

The Medicare DSH payment will be reduced to 25 percent of the amount they previously would have received under the current statutory formula in PRICER. The calculation of the Medicare DSH payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment will be applied in PRICER.

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2017 IPPS final rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2017. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY2013-2015). The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations. In addition, the estimated per discharge uncompensated care payment amount will be included as a federal payment for sole-community hospitals to determine if a claim is paid under the hospital-specific rate or federal rate and for Medicare-dependent hospitals to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the federal rate. The total uncompensated care payment amount displayed in the Medicare DSH supplemental data file on the CMS website will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

### Recalled devices

A hospital's IPPS payment is reduced, for specified MS-DRGs when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device.

New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs that were already on the list.

There are no new MS-DRGs for FY 2017 subject to the policy for replaced devices offered without cost or with a credit.

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## LTCH PPS FY 2017 update

### FY 2017 LTCH PPS rates and factors

FY 2017 LTCH PPS rates and factors are as follows:

**FY 2017 LTCH PPS rates and factors**

| Factors | Rates |
|---|---|
| LTCH PPS standard federal rates | Rates based on successful reporting of quality data.<br>▪ Full update (quality indicator on PSF = 1): $42,476.41<br>▪ Reduced update (quality indicator on PSF = 0 or blank): $41,641.49 |
| Labor share | 66.5 percent |
| Non-labor share | 33.5 percent |
| High-cost outlier fixed-loss amount for standard federal rate discharges | $21,943 |
| High-cost outlier fixed-loss amount for site-neutral rate discharges | $23,573 |

The LTCH PPS Pricer has been updated with the version 34.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2016, and on or before September 30, 2017.

**1. Application of the site-neutral payment rate**

Section 1206(a) of Public Law 113–67 amended Section 1886(m) of the Social Security Act to establish patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015.

The application of the site-neutral payment rate is codified in the regulations at *§412.522*. Additional information on the final policies implementing the application of the site neutral payment rate can be found in the FY 2016 final rule (80 FR 49601-49623). Section 231 of the Consolidated Appropriations Act created a temporary exception to the site neutral payment rate for certain discharges from certain LTCHs. Additional information on the provisions of Section 231 can be found in the interim final rule with comment period (IFC) published in the *Federal Register* April 21, 2016 (81 FR 25430) and finalized in the FY 2017 IPPS/LTCH final rule (81 FR 57068). Information on the requirements implementing the application of the site neutral payment rate is available in CRs 9015 and 9599.

The provisions of Section 1206(a) of Public Law 113-67 establishes a transitional blended payment rate for site neutral payment rate LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017, which is implemented in the regulations at § 412.522(c)(1). The blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge and 50 percent of the LTCH PPS standard federal payment rate that would have applied to the discharge if the provisions of Public Law 113-67 had not been enacted. This transitional blended payment rate for site neutral payment rate LTCH discharges is included in the Pricer logic.

### Discharge payment percentage

Beginning with LTCHs' FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their "discharge payment percentage" (DPP), which is the ratio (expressed as a percentage) of the LTCHs' FFS discharges which received LTCH PPS standard federal rate payment to the LTCHs' total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH (other than a sub-clause II LTCH) of its DPP upon final settlement of the cost report.

### LTCH quality reporting (LTCHQR) program

The Affordable Care Act (Section 3004(a)) requires the establishment of the long-term care hospital quality reporting (LTCHQR) program. For FY 2017, the annual update to a standard federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR program for that year.

### Cost of living adjustment (COLA) under the LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2017, and are the same COLAs established in the FY 2014 IPPS/LTCH PPS final rule. The applicable COLAs are the same as those in Tables 2 listed earlier in this article.

## Additional information

The official instruction, CR 9723, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3832CP.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*.

## Document history

| Date of change | Description |
|---|---|
| August 11, 2017 | Article revised to reflect a revised CR 9723 issued August 9, 2017. In the CR, the out migration values in attachment 7 of the CR were revised. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. |
| October 26, 2016 | Initial article released. |

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# Correcting payment of IPPS transfer claims assigned to MS-DRG 385

## Provider type affected

This *MLN Matters*® article is intended for Inpatient Hospitals submitting transfer claims assigned to Medicare severity diagnosis related group (MS-DRG) 385 to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

## Provider action needed

This article, based on change request (CR) 10145, informs the MACs about a correction to Medicare's fiscal intermediary shared system (FISS) assignment of review code for inpatient prospective payment system (IPPS) transfer claims assigned MS-DRG 385, so that the IPPS pricer will calculate the per diem transfer payment. Another correction allows Part A deductible, identified by a value code, on MSP same day transfer claims. Please be sure your billing staffs are aware of these corrections.

## Background

The Centers for Medicare & Medicaid Services (CMS) recently discovered that IPPS transfer claims classified into MS DRG 385 are receiving the full prospective payment as defined in 42 *Code of Federal Regulations* (CFR) 412.2(b), instead of the graduated per diem rate for each day of the patient's stay in that hospital, not to exceed the amount that would have been paid if the patient had been discharged to another setting (42 CFR 412.4 (f)).

Prior to October 1, 2007, transferring hospitals with discharges classified into DRG 385 (neonates, died, or transferred) had their payments calculated on the same basis as those receiving the full prospective payment because the weighting factors for this DRG assume that the patient will be transferred, since a transfer is part of the definition.

With the implementation of MS-DRGs in fiscal year (FY) 2008, MS DRG 385 became inflammatory bowel disease with major complication or comorbidity (MCC). Since the definition of this MS DRG does not include a transfer, it should be subject to the transfer payment policy.

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*MLN Matters*® Number: MM9723 *Revised*
Related Change Request (CR) #: CR 9723
Related CR Release Date: August 9, 2017
Effective Date: October 1, 2016
Related CR Transmittal #: R3832CP
Implementation Date: October 3, 2016



**Operating rates for wage index > 1**

| | Hospital submitted quality data and is a meaningful electronic health record (EHR) user (Update = 1.65 percent) | | Hospital did NOT submit quality data and is a meaningful EHR user (Update = 0.975 percent) | | Hospital submitted quality data and is NOT a meaningful EHR user (Update = -0.375 percent) | | Hospital did NOT submit quality data and is NOT a meaningful EHR user (Update = -1.05 percent) | |
|---|---|---|---|---|---|---|---|---|
| | **Labor** | **Nonlabor** | **Labor** | **Nonlabor** | **Labor** | **Nonlabor** | **Labor** | **Nonlabor** |
| **National** | $3,839.23 | $1,676.91 | $3,813.74 | $1,665.77 | $3,762.75 | $1,643.50 | $3,737.25 | $1,632.37 |
| **PR national** | $3,839.23 | $1,676.91 | $3,839.23 | $1,676.91 | $1,676.91 | $3,839.23 | $3,839.23 | $1,676.91 |

**Operating rates for wage index < or = 1**

| | Hospital submitted quality data and is a meaningful EHR user (Update= 1.65 percent) | | Hospital did NOT submit quality data and is a meaningful EHR user (Update= 0.975 percent) | | Hospital submitted quality data and is NOT a meaningful EHR user (Update= -0.375 percent) | | Hospital did NOT submit quality data and is NOT a meaningful EHR user (Update= -1.05 percent) | |
|---|---|---|---|---|---|---|---|---|
| | **Labor** | **Nonlabor** | **Labor** | **Nonlabor** | **Labor** | **Nonlabor** | **Labor** | **Nonlabor** |
| **National** | $3,420.01 | $2,096.13 | $3,397.30 | $2,082.21 | $3,351.88 | $2,054.37 | $3,329.16 | $2,040.46 |
| **PR national** | $3,420.01 | $2,096.13 | $3,420.01 | $2,096.13 | $3,420.01 | $2,096.13 | $3,420.01 | $2,096.13 |

# Inpatient psychiatric facilities prospective payment system fiscal year 2018

## Provider types affected

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

## Provider action needed

Change request (CR) 10214 identifies changes that are required as part of the annual inpatient psychiatric facilities prospective payment system (IPF PPS) update from the fiscal year (FY) 2018 IPF PPS notice, displayed August 2, 2017. These changes are applicable to IPF discharges occurring during FY October 1, 2017, through September 30, 2018. This recurring update applies to *Claims Processing Manual*, Chapter 3, Section 190.4.3. Make sure your billing staff is aware of these changes.

## Background

On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a final rule that established the PPS for IPF under the Medicare program in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (that is, bad debts, and graduate medical education). CMS is required to make updates to this prospective payment system annually.

**Key points of CR 10214**

### Market Basket Update

For FY 2018, CMS is using the 2012-based IPF market basket to update the IPF PPS payments (that is, the Federal per diem base rate and electroconvulsive therapy (ECT) payment per treatment). The 2012-based IPF market basket update for FY 2018 is 2.6 percent. However, this 2.6 percent is subject to two reductions required by the Social Security Act (the Act), as described below.

Section 1886(s)(2)(A)(ii) of the Act requires the application of an "other adjustment" that reduces any update to the IPF market basket update by percentages specified in Section 1886(s)(3) of the Act for rate year (RY) beginning in 2010 through the RY beginning in 2019. For the FY beginning in 2017 (that is, FY 2018), Section 1886(s)(3)(E) of the Act requires the reduction to be 0.75 percentage point. CMS implemented that provision in the FY 2018 IPF PPS notice.

In addition, Section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in Section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for

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## DRG

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An unrelated correction also contained in this CR will allow Medicare covered and payable expenses paid by a primary payer and billed with the value code for Medicare Part A deductible

As a result, MACs will no longer bypass transfer logic when assigning review codes on IPPS claims classified into MS-DRG 385 with a discharge status code 02, 07, 66, 82, or 94 and the through date of service is equal to or later than 01/01/2018.

An unrelated correction also contained in this CR will allow the Part A deductible, identified by a value code, on Medicare secondary payer (MSP) same day transfer claims, as it currently does for regular MSP claims, for Medicare covered services that are paid by the primary payer.

CR 10145 contains no new policy. It improves the implementation of existing Medicare payment policies and allows the claims processing system to conform to 42 CFR 411.30 (b) which states, "Expenses for Medicare covered services that are paid for by primary payers are credited toward the Medicare Part A and Part B deductibles."

## Additional information

The official instruction, CR 10145, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1870OTN.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 28, 2017 | Initial article released |

*MLN Matters*® Number: MM10145
Related CR Release Date: July 27, 2017
Related CR Transmittal Number: R1870OTN
Related Change Request (CR) Number: 10145
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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the RY beginning in 2012 (that is, a RY that coincides with a FY), and each subsequent RY. For the FY beginning in 2017 (that is, FY 2018), the reduction is 0.6 percentage point. CMS implemented that provision in the FY 2018 IPF PPS notice.

CMS updated the IPF PPS base rate for FY 2018 by applying the adjusted market basket update of 1.25 percent (which includes the 2012-based IPF market basket update of 2.6 percent, an ACA required 0.75 percentage point reduction to the market basket update, and an ACA required productivity adjustment reduction of 0.6 percentage point) and the wage index budget neutrality factor of 1.0006 to the FY 2017 Federal per diem base rate of $761.37 to yield a FY 2018 federal per diem base rate of $771.35. Similarly, applying the adjusted market basket update of 1.25 percent and the wage index budget neutrality factor of 1.0006 to the FY 2017 ECT payment per treatment of $327.78 yields an ECT payment per treatment of $332.08 for FY 2018.

### Inpatient psychiatric facilities quality reporting program (IPFQR)

Section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014. CMS finalized new requirements for quality reporting for IPFs in the hospital inpatient prospective payment system for acute care hospitals and the long-term care hospital.

Prospective payment system and fiscal year 2013 rates", final rule (August 31, 2012) (77 FR 53258, 53644 through 53360). Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent FY, the Secretary will reduce any annual update to a standard federal rate for discharges occurring during the FY by two percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, a two percentage point reduction is applied to the federal per diem base rate and the ECT payment per treatment as follows:

- For IPFs that fail to submit quality reporting data under the IPFQR program, a -0.75 percent annual update (an update consisting of 1.25 percent annual update (that is, the adjusted market basket update) reduced by 2.0 percentage points in accordance with Section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0006 are applied to the FY 2017 federal per diem base rate of $761.37, yielding a federal per diem base rate of $756.11 for FY 2018.
- Similarly, a -0.75 percent annual update and the 1.0006 wage index budget neutrality factor are applied to the FY 2017 ECT payment per treatment of $327.78, yielding an ECT payment per treatment of $325.52 for FY 2018.

**PRICER updates: IPF PPS FY 2018 (October 1, 2017 – September 30, 2018)**

- The federal per diem base rate is $771.35 for IPFs that complied with quality data submission requirements.
- The federal per diem base rate is $756.11 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.
- The fixed dollar loss threshold amount is $11,425.
- The IPF PPS wage index is based on the FY 2017 pre-floor, pre-reclassified acute care hospital wage index.
- The labor-related share is 75.0 percent.
- The non-labor related share is 25.0 percent.
- The ECT payment per treatment is $332.08 for IPFs that complied with quality data submission requirements.
- The ECT payment per treatment is $325.52 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

### The national urban and rural cost to charge ratios for the IPF PPS fiscal year 2018 cost to charge ratios for the IPF prospective payment system FY 2018

| CCRs | Rural | Urban |
|---|---|---|
| National median CCRs | 0.5930 | 0.4420 |
| National ceiling | CCRs 1.9634 | 1.7071 |

CMS is applying the national cost-to-charge ratios (CCRs) to the following situations:

- For new IPF facilities that have not submitted their first Medicare cost report, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

### International Classification of Diseases, Tenth Revision Clinical Modifications/Procedural Classification System updates

The adjustment factors are unchanged for the FY 2018 IPF PPS. However, CMS updated the ICD-10- CM/PCS code set as of October 1, 2017. These updates affect the International Classification of Diseases, Tenth Revision Clinical Modifications/Procedural Classification System (ICD-10-CM/PCS) codes which underlie the IPF PPS MS-DRG categories, the IPF PPS comorbidity categories and the IPF PPS code first list. The updated FY 2018 MS-DRG code lists are available on the IPPS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*, and the updated FY 2018 IPF PPS comorbidity categories,

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and IPF PPS code first list are available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html*.

### FY 2018 IPF PPS wage index

The FY 2018 final IPF PPS wage index is available online at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html*. This FY 2018 IPF PPS final wage index adopts minor OMB changes to a few statistical area delineations.

### Cost of living adjustment (COLA) adjustment

The IPF PPS COLA factors lists were updated for FY 2018. See Table 1 and 2:

**Table 1: Alaska COLAs for IPF prospective payment system FY 2018**

| Alaska: | Cost of living adjustment factor |
|---|---|
| City of Anchorage and 80-kilometer (50-mile) radius by road | 1.25 |
| City of Fairbanks and 80-kilometer (50-mile) radius by road | 1.25 |
| City of Juneau and 80-kilometer (50-mile) radius by road | 1.25 |
| Rest of Alaska | 1.25 |

**Table 2: Hawaii COLAs for IPF prospective payment system FY 2018**

| Hawaii | Cost of living adjustment factor |
|---|---|
| City and County of Honolulu | 1.25 |
| County of Hawaii | 1.21 |
| County of Kauai | 1.25 |
| County of Maui and County of Kalawao | 1.25 |

### Rural adjustment

Due to the OMB CBSA changes implemented in FY 2016, several IPFs had their status changed from "rural" to "urban" as of FY 2016. As a result, these rural IPFs were no longer eligible for the 17 percent rural adjustment which is part of the IPF PPS. Rather than ending the adjustment abruptly, CMS phased out the adjustment for these providers over a three year period. In FY 2016, the adjustment for these newly-urban providers was two-thirds of 17 percent, or 11.3 percent. For FY 2017, the adjustment for these providers is one-third of 17 percent, or 5.7 percent. For FY 2018 and subsequent years, no rural adjustment will be given to these providers. There is no rural phase-out for the single provider whose status changed from rural to urban as a result of the July 15, 2015, OMB Bulletin 15-01.

## Additional information

The official instruction, CR 10214, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2017Downloads/R3826CP.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 |
|---|---|
| August 7, 2017 | Initial article issued |

*MLN Matters*® Number: MM10214
Related Change Request (CR) Number: 10214
Related CR Release Date: August 4, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3826CP
Implementation Date: October 2, 2017



## 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.

The new Medicare cards will be mailed between April 2018 and April 2019. Resources are available to prepare you for this change at *https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp*.

# Quarterly update to the end-stage renal disease prospective payment system

## Provider types affected

This *MLN Matters*® article is intended for end-stage renal disease (ESRD) facilities that submit claims to Medicare administrative contractors MACs) for ESRD services provided to Medicare beneficiaries.

## Provider action needed

Change request (CR) 10193 provides the October 1, 2017, update to the lists of items and services that are subject to Part B consolidated billing (CB) and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. Make sure your billing staff is aware of these changes.

## Background

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b)) required the implementation of an ESRD PPS effective January 1, 2011. The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment.

The ESRD PPS includes CB requirements for limited Part B services included in the ESRD facility's bundled payment. CMS periodically updates the lists of items and services that are subject to Part B CB and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

For October, the CB requirements for laboratory services included in the ESRD PPS are updated by adding the following Healthcare Common Procedure Coding System (HCPCS) and *Current Procedural Terminology* (CPT®) codes to the list:

- G0499 - Hepatitis B screening in non-pregnant, high risk individual includes Hepatitis B Surface Antigen (HBSAG) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to HBSAG (anti-hbs) and hepatitis B core antigen (anti-hbc)
- 87341 - Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiplestep method; Hepatitis B Surface Antigen (HBSAG) neutralization

## Additional information

The official instruction, CR 10193, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3833CP.pdf*. The 2017 ESRD PPS CB List is attached to CR 10193.

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 |
|---|---|
| August 14, 2017 | Initial article released. |

*MLN Matters*® Number: MM10193
Related CR Release Date: August 11, 2017
Related CR Transmittal Number: R3833CP
Related Change Request (CR) Number: CR 10193
Effective Date: October 1, 2017
Implementation Date: October 2, 2017



# Part B billing for certain new biosimilar biological products before the modifier is implemented

Modifiers that identify the manufacturer of a biosimilar biological product are required on Part B claims. CMS updates assignment of modifiers to specific HCPCS codes quarterly. In situations where a HCPCS code is already associated with one or more modifiers and a new biosimilar biological product becomes available before its corresponding manufacturer's modifier becomes effective, a not otherwise classified (NOC) code without a modifier may be used to bill for the new biosimilar product. For more information, visit the Part B biosimilar biological product payment and required modifiers (*https://go.usa.gov/xRQgQ*) web page.

# October 2017 quarterly ASP Medicare Part B drug pricing files and revisions to prior files

## Provider types affected

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

## What you need to know

Change request (CR) 10187 instructs MACs to download and implement the October 2017 and, if released, the revised July 2017, April 2017, January 2017, and October 2016, ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) data center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2017, with dates of service October 1, 2017, through December 31, 2017. Make sure your billing staffs are aware of these changes.

## Background

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

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

For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*. For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of durable medical equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

## Additional information

The official instruction, CR 10187, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3809cp.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 21, 2017 | Initial article released |

*MLN Matters*® Number: MM10187
Related CR Release Date: July 21, 2017
Related CR Transmittal Number: R3809CP
Related Change Request (CR) Number: 10187
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

# July quarterly update for 2017 DMEPOS fee schedule

***Note:*** *This article was revised August 3, 2017, to reflect an updated change request (CR). That CR updated the policy section on complex rehabilitative power wheelchair accessories & seat and back cushions. The CR release date, transmittal number and link to the CR also changed. All other information is the same. This information was previously published in the May 2017 Medicare A Connection, pages 25-26.*

## 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.

## Provider action needed

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 rural 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

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 (codes K0848 through K0864) with dates of service on or after July 1, 2017. The fee schedule amounts associated with the KU modifier were not adjusted using information from the competitive bidding program in accordance with Section 2 of Patient Access and Medicare Protection Act (PAMPA) for dates of service January 1 through December 31, 2016. Section 16005 of the 21st Century Cures Act then extended the effective date through June 30, 2017. Effective for dates of service on or after July 1, 2017, taking into consideration the exclusion at section 1847(a)(2)(A) of the Social Security Act, the policy for these items is revised. As a result, payment for these items furnished in connection with a group three complex rehabilitative power wheelchair and billed with the KU modifier will be based on the unadjusted fee schedule amounts updated in accordance with Section 1834(a)(14) of the Act. The list of HCPCS codes associated with the KU modifier is available in Transmittal 3713, CR 9966, and dated February 3, 2017. The updated DMEPOS fee schedule files have been released.

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### 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

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-andGuidance/Guidance/Transmittals/2017Downloads/R3824CP.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/MonitoringPrograms/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

## Document history

| Date of change | Description |
|---|---|
| August 2, 2017 | The article was revised August 3, 2017, to reflect an updated CR. That CR updated the policy section on complex rehabilitative power wheelchair accessories & seat and back cushions. The CR release date, transmittal number and link to the CR were also changed. |
| May 2, 2017 | Initial article released |

*MLN Matters*® Number: MM10071 *Revised*
Related Change Request (CR) # 10071
Related CR Release Date: August 2, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3824CP
Implementation Date: July 3, 2017



## Quarterly provider update

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

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

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at *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.

# Quarterly influenza virus vaccine code update – January 2018

## Provider types affected

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

## Provider action needed

Change request (CR) 10196, from which this article was developed, provides instructions for payment and edits for the common working file (CWF) and the fiscal intermediary shared system (FISS) to include and update new or existing influenza virus vaccine codes. The influenza virus vaccine code set is updated on a quarterly basis. This update will include one new influenza virus vaccine code: 90756. Please make sure your billing staffs are aware of this update.

## Background

Effective for claims processed with dates of service (DOS) on or after January 1, 2018, influenza virus vaccine code 90756 (Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use) will be payable by Medicare. This new code will be included on the 2018 Medicare physician fee schedule database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

During the interim period of August 1, 2017, through December 31, 2017, MACs will use code Q2039 (Influenza virus vaccine, not otherwise specified) to handle bills for this new influenza virus vaccine product (Influenza virus vaccine, quadrivalent (ccIIV4). Q2039 is already an active code.

The new influenza virus vaccine code 90756 will then be implemented with the January 2018 release for DOS on or after January 1, 2018.

Effective for dates of service on or after August 1, 2017, MACs will use the CMS seasonal influenza vaccines pricing website 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 Q2039 and 90756.

Medicare will issue further instructions on how to handle claims using Q2039 for the new influenza virus vaccine product between August 1, 2017, and December 31, 2017. MACs will use existing processes to handle these claims.

The new influenza virus vaccine code (90756) is not retroactive to August 1, 2017. Claims will not be accepted for influenza virus vaccine code 90756 between the DOS August 1, 2017, and December 31, 2017. **If claims are received in January 2018, with code 90756 for DOS between August 1, 2017, and December 31, 2017, claims will be rejected or returned as unprocessable.**

### New vaccine description

**Code 90756 – Long description**: Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use TOS code: V

- **Short description**: CCIIV4 VACC ABX FREE IM
- **Medium description**: CCIIV4 VACCINE ANTIBIOTIC FREE 0.5 ML DOS IM USE Long

### Payment basis

Based on reasonable cost, MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:

- Hospitals (types of bill 12x and 13x)
- Skilled nursing facilities (22x and 23x)
- Home health agencies (34x)
- Hospital-based renal dialysis facilities (72x), and
- Critical access hospitals (85x)

Based on the lower of the actual charge or 95 percent of the average wholesale price (AWP), MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:

- Indian service hospitals (IHS) (12x and 13x)
- IHS hospices (81x and 82x) and
- IHS critical access hospitals (85x)
- Comprehensive outpatient rehabilitation facilities (CORFs) (75x), and
- Independent RDFs (72x)

**Note**: In all cases, coinsurance and deductible to not apply.

MACS will suspend and manually price claims when the HCPC file rate is blank for:

- IHS hospitals (12x, 13x), hospices (81x and 82x), and IHS CAHs (85x)
- CORFs (75x) and
- Independent RDFs (72x)

### Messages for denied claims

MACs will return as unprocessable claims submitted with Q2039 for the DOS January 1, 2018, through July 31, 2018, when code 90756 should have been submitted, using the following messages:

- **Claims adjustment reason code (CARC):** 181 – Procedure code was invalid on the date of service.
- **Remittance advice remark code (RARC):** N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.
- **Group code**: CO (contractual obligation)

## Additional information

The official instruction, CR 10086, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3827CP.pdf*.

If you have any questions, please contact your MAC at

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# Screening for hepatitis B virus infection

***Note**: This article was revised August 8 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. Also, a clarification was made under "Key points of CR 9859" to denote that HBV is not separately payable for end-stage renal disease (ESRD) TOB 72x unless reported with modifier AY. Another bullet point was added under "Key points of CR 9859" to show that contractor pricing applies to G0499 with dates of service September 28, 2016, through December 31, 2017. All other information is unchanged. This information was previously published in the July 2017 Medicare A Connection, pages 13-19.*

## 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

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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 |
|---|---|
| August 9, 2017 | This article was revised to correctly show in all appropriate places the code of Q2039. In the original article, Q0239 was mistakenly referenced in two places and that is corrected to show Q2039. All other information remains the same. |
| August 7, 2017 | Article initially released |

*MLN Matters*® Number: MM10196
Related CR Release Date: August 4, 2017
Related CR Transmittal Number: R3827CP
Related Change Request (CR) Number: 10196
Effective Date: August 1, 2017
Implementation Date: January 2, 2018

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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

### 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 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 unless reported with modifier AY.)
- Contractor pricing applies to G0499 with dates of service September 28, 2016, through December 31, 2017.

### 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

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- 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 |
| 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 *https://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."

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- 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 *https://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 *https://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 at *https://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 *https://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).

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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).

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 *https://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 *https://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 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/R3831CP.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 |
|---|---|
| August 8, 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. A clarification was made under "Key points of CR 9859" to denote that HBV is not separately payable for ESRD TOB 72x unless reported with modifier AY. Another bullet point was added under "Key points of CR 9859" to show that contractor pricing applies to G0499 with dates of service September 28, 2016, through December 31, 2017. All other information is unchanged. |
| 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. |

See **HBV**, next page

# National coverage determination leadless pacemakers

## Provider type affected

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

## Provider action needed

Change request (CR) 10117 informs MACs that effective January 18, 2017, the Centers for Medicare & Medicaid Services (CMS) covers leadless pacemakers through coverage with evidence development (CED) when procedures are performed in CMS-approved CED studies. Please make your billing staffs are aware of this determination.

## Background

The leadless pacemaker eliminates the need for a device pocket and insertion of a pacing lead which are integral elements of traditional pacing systems. The removal of these elements eliminates an important source of complications associated with traditional pacing systems while providing similar benefits. Leadless pacemakers are delivered via catheter to the heart, and function similarly to other transvenous single-chamber ventricular pacemakers. Prior to January 18, 2017, there was currently no national coverage determination (NCD) in effect.

On January 18, 2017, CMS issued an NCD to cover leadless pacemakers through CED. CMS covers leadless pacemakers when procedures are performed in studies approved by the Food & Drug Administration (FDA). CMS also covers, in prospective longitudinal studies, leadless pacemakers that are used in accordance with the FDA-approved label for devices that have either:

- An associated ongoing FDA-approved post-approval study; or
- Completed an FDA post-approval study.

For such coverage, Medicare will allow payment for claims for dates of service on or after January 18, 2017, for leadless pacemakers through CED when billed with the following CPT® codes:

- 0387T – Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular
- 0389T – Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system.
- 0390T – Peri-procedural device evaluation (in person) and programming of device system parameters before or after surgery, procedure or test with analysis, review and report, leadless pacemaker system.
- 0391T – Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system.

Effective for dates of service on or after January 18, 2017, MACs will allow the following ICD-10 diagnosis codes on claims for leadless pacemakers:

- Z00.6 – Encounter for examination for normal comparison and control in clinical research program.

Effective for dates of service on or after January 18, 2017, contractors shall return claims as unprocessable with the listed procedure codes billed without ICD-10 Z00.6 and use the following messages:

- CARC 16 -Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.
- RARC M76 -Missing/incomplete/invalid diagnosis or condition

Effective for claims with dates of service on or after January 18, 2017, modifier **Q0** – Investigational clinical service provided in a clinical research study that is an approved clinical research study, must also be included.

See **NCD**, next page

## HBV

from previous page

| Date | Description |
|---|---|
| May 4, 2017 | Initial article released. |

*MLN Matters*® Number: MM9859 *Revised*
Related Change Request (CR) #: CR 9859
Related CR Release Date: August 4, 2017
Effective Date: September 28, 2016

Related CR Transmittal #: R3831CP and R198NCD
Implementation Date: January 2, 2018

## NCD

from previous page

Effective for dates of service on or after January 18, 2017, MACs will return claims with the procedure codes listed billed without modifier Q0 and use the following messages:

- CARC 4: "The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N572: This procedure not payable unless appropriate non-payable reporting.
- Group code – contractual obligation (CO).

Remember to include the eight-digit clinical trial identifier on the claim. Effective for claims with dates of service on or after January 18, 2017, MACs will return claims as unprocessable that are billed with the Q0 modifier and do not contain the eight-digit clinical trial identifier in item 23 of the CMS-1500 form or the electronic equivalent. Use the following messages:

- CARC 16: "Claim/service lacks information which is needed for adjudication 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.)"
- RARC MA50: Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.
- Group code – Contractual obligation (CO).

Effective for dates of service in or after January 18, 2017, MACs shall only pay claims for leadless pacemakers when services are provided in one of the following places of dervice (POS):

- POS 06 – Indian health service provider based facility
- POS 21 – Inpatient hospital
- POS 22 – On campus-outpatient hospital
- POS 26 – Military treatment facility

Where the proper POS code is not included and the claim is rejected/denied, the following messaging should be used:

- CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **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 have web access, you may contact the contractor to request a copy of the NCD.
- Group code – contractual obligation (CO)

MACs will not search their files for claims for leadless pacemakers with dates of service between January 18, 2017, and the implementation date of CR 10117, but may adjust claims that you bring to their attention.

All clinical research study protocols must address pre-specified research questions, adhere to standards of scientific integrity and be reviewed and approved by CMS. Approved studies will be posted to the CMS website at *https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index.html*. The process for submitting a clinical research study to Medicare is outlined in the NCD.

Leadless pacemakers are non-covered outside of CMS-approved studies.

**Note**: This revision to the *Medicare NCD Manual* is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, and MACs with the federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent MACs, 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).

### Additional information

The official instruction, CR 10117, issued to your MAC regarding this change consists of two transmittals. The first is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3815CP.pdf* and the second is at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R201NCD.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 |
|---|---|
| August 1, 2017 | Initial article released. |

*MLN Matters*® Number: MM10117
Related Change Request (CR) Number: 10117
Related CR Release Date: July 28, 2017
Effective Date: January 18, 2017
Related CR Transmittal Number: R201NCD and R3815CP
Implementation Date: August 29, 2017, for local MAC system edits; January 2, 2018, for shared system edits

# ICD-10 coding revisions to national coverage determinations

## Provider types affected

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

## Provider action needed

Change request (CR) 10184 outlines edits to International Classification of Diseases, 10th Revision (ICD-10) and other coding updates specific to national coverage determinations (NCDs) that will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. The following link provides the NCD spreadsheets included with this CR 10184 at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10184.zip*.

## Background

CR 10184 constitutes a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

Previous NCD coding changes appear in ICD-10 quarterly updates that are available at *https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

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

**Note**: The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete general equivalence mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR 10084 makes coding and clarifying adjustments to the following NCDs:

- NCD160.18 - Vagus nerve xtimulation
- NCD210.4.1 - Counseling to prevent tobacco use
- NCD220.6.17 - Positron emission tomography (PET) for solid tumors
- NCD220.6.20 - PET beta amyloid in dementia/neurological disorders
- NCD210.13 - Screening for hepatitis C virus

**Note/clarification**: MACs will use default Council for Affordable Quality Healthcare Committee on Operating Rules (CAQH CORE) messages where appropriate:

- Remittance advice remark code (RARC) N386 with claim adjustment reason code (CARC) 50, 96, and/or 119
- See latest CAQH CORE update

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

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

## Additional information

The official instruction issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1875OTN.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 |
|---|---|
| August 9, 2017 | Initial article released |

*MLN Matters*® Number: MM10184
Related CR Release Date: July 27, 2017
Related CR Transmittal Number: R1875OTN
Related Change Request Number: 10184
Effective Date: January 1, 2018
Implementation Date: September 13, 2017, for local edits; January 2, 2018, forshared systems

# Percutaneous image-guided lumbar decompression for LSS

***Note:*** *This article was revised July 26, 2017, to reflect the revised CR 10089 issued July 25. In the article, the transmittal numbers, CR release date, implementation date, and the web addresses for accessing the transmittals are revised. All other information remains the same. This information was previously published in the June 2017 Medicare A Connection, page 43.*

## Provider type affected

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

## Provider action needed

Change request (CR) 10089 announces that effective for dates of service on or after December 7, 2016, Medicare will cover percutaneous image-guided lumbar decompression (PILD) under coverage with evidence development (CED) for beneficiaries with lumbar spinal stenosis (LSS) who are enrolled in a Center for Medicare & Medicaid Services (CMS)-approved prospective longitudinal study. PILD procedures using an FDA-approved/cleared device that completed a CMS-approved prospective, randomized, controlled clinical trial (RCT) that met the criteria are listed in the January 2014 NCD (CR 8757, see related *MLN Matters*® article at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8757.pdf*).

## Background

CMS currently covers PILD under the CED paradigm. PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. This is a procedure proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. This procedure is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (for example, fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epiduragram.

Section 1862(a)(1)(E) of the Social Security Act (the Act) authorizes coverage for PILD for beneficiaries with LSS under CED. On January 9, 2014, CMS posted its first NCD (150.13) covering PILD for beneficiaries with LSS when provided in a RCT meeting certain conditions under CED. Clinical studies must be designed using current validated and reliable measurement instruments and clinically appropriate comparator treatments for patients randomized to the non-PILD group.

On April 13, 2016, CMS accepted a complete formal request for a reconsideration of the NCD that limited

coverage of PILD for LSS to a CMS-approved prospective RCT. After considering the related published literature and public comments as required by Section 1862(l) of the Act, CMS will expand the January 2014 NCD to cover PILD for LSS under CED through a prospective longitudinal study that meets certain criteria listed in Chapter 1, Section 150.13 of the *NCD Manual* (Pub. 100-03). You should refer to Chapter 1, Section 310 of the *NCD Manual*, as well as Chapter 32, Sections 69 and 330, of the *Medicare Claims Processing Manual* (Pub. 100-04) for more information.

**Note:** As mentioned in MM8954, there are two distinct procedure codes that are to be used: G0276 only for clinical trials that are blinded, randomized, and controlled, and contain a placebo procedure control arm (use CR 8954 for claim processing instructions), and 0275T for ***all*** other approved clinical trials (use CR 8757 for claim processing instructions).

CR 10089 does not replace but rather is in addition to CR 8757 and CR 8954.

## Additional information

You can review the list of approved clinical studies related to PILD for LSS at *https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html*.

The official instruction, CR 10089, issued to your MAC regarding this change consists of two transmittals. The first modifies the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3811CP.pdf*. The second updates the NCD manual and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R200NCD.pdf*. The revised sections of both manuals are attached to their respective transmittals.

You may also want to review *MLN Matters*® articles MM8401 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf* and MM8954 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8954.pdf*.

See **PILD**, next page

# New search capability simplifies LCD lookup

Providers in need of a quick and direct method to locate local coverage determinations (LCDs) by procedure code now have a simple way to do so by using First Coast Service Options' website search functionality.

Instead of going to an outside website, providers can now locate LCDs faster by searching procedure codes, keywords, or International Classification of Diseases 10th revision codes (ICD-10s) using First Coast's own website search bar.

To find an LCD that corresponds with a specific procedure code, providers may use the site's search bar – located at the top of every page – to search and find an LCD containing that procedure code. Currently, providers use the Medicare Coverage Database (MCD) provided by the Centers for Medicare & Medicaid Services (CMS) in order to find what they are looking for. All of the LCD data is now on the First Coast website, making it simple to find the LCD providers are researching.

Providers can now simply enter a procedure code, keyword, or ICD-10 code into the website search bar and search "LCDs only" to find the matching results. This search function replaces the multiple steps currently required by other methods, and lets providers locate the corresponding LCDs by using First Coast's own LCD data.

## Multiple ways to locate and view data on the MCD

Options available within the MCD will also help you find LCDs and national coverage determinations (NCDs).

QUICK SEARCH – The MCD allows users to search both the NCD and LCD databases using a variety of criteria such as keyword, diagnosis/procedure, and date. Quick search is located at the top right of the *MCD overview page*.

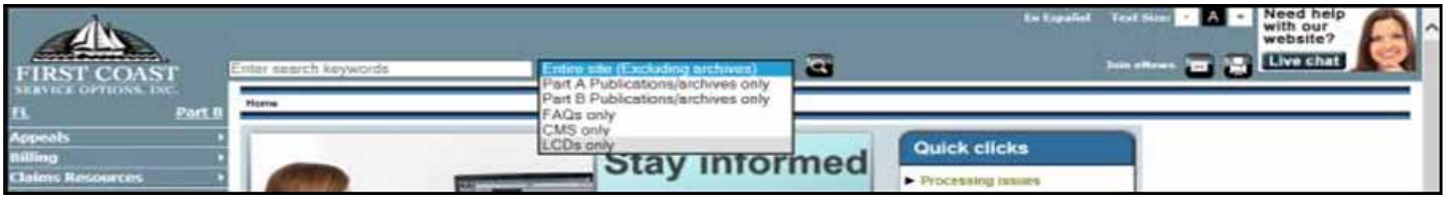
Click *ADVANCED SEARCH* to use additional filters to find exactly what you are looking for.

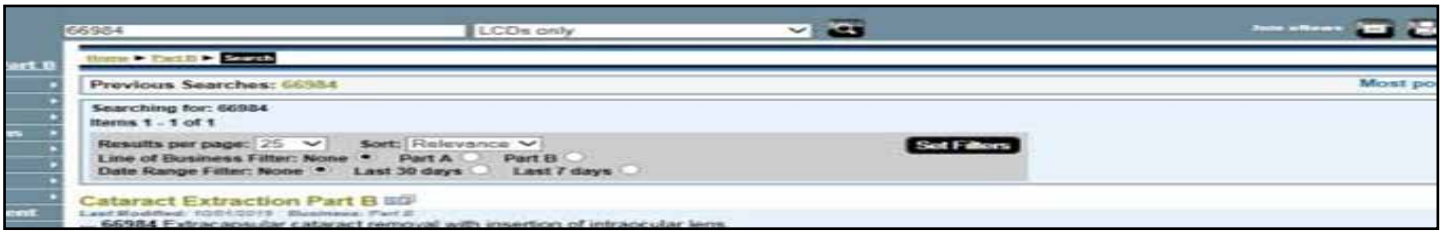
*INDEXES* – Provides users with pre-defined lists of national and local coverage documents.

*REPORTS* – Provides users with reports of national and local coverage data.

*DOWNLOADS* – Allows users to download complete sets of LCDs and articles and the complete set of NCDs.

For more information about using the MCD, *click here*.




## PILD

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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 |
|---|---|
| June 5, 2017 | Initial article released. |
| July 26, 2017 | The article was revised July 26, 2017, to reflect the revised CR 10089 issued July 25. In the article, the transmittal numbers, CR release date, implementation date, and the web addresses for accessing the transmittals are revised. All other information remains the same. |

*MLN Matters*® Number: MM10089 *Revised*
Related Change Request (CR) Number: 10089
Related CR Release Date: July 25, 2017
Effective Date: December 7, 2016
Related CR Transmittal Number: R3811CP and R200NCD
Implementation Date: June 27, 2017

# Upcoming provider outreach and educational events

## Medicare Speaks 2017 Jacksonville

**Date: Thursday-Friday, September 14-15**
**Time: 7:30 a.m.-4:15 p.m.**
**Type of Event:** Face-to-face
*https://medicare.fcso.com/Medicare_Speaks/0371641.asp*

## Medicare Part A changes and regulations

**Date: Wednesday, September 19**
**Time: 10:00-11:30 a.m.**
**Type of Event:** Webcast
*https://medicare.fcso.com/Events/0380043.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®

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*® 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 *MLN Connects*® to its membership as appropriate.

# MLN Connects® for July 27, 2017

*MLN Connects® for July 27, 2017*

*View this edition as a PDF*

## News & Announcements

- Home Health Agencies: CMS Proposes 2018 and 2019 Payment Changes
- New Medicare Card (formerly called SSNRI)
- Quality Payment Program: Explanation of Special Status Calculation
- Updated CMS Measures Inventory Posted
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis
- Anniversary of the American Disabilities Act

## Provider Compliance

- Hospital Discharge Day Management Services CMS Provider Minute Video

## Claims, Pricers & Codes

- 2018 ICD-10-CM POA Exempt Codes Available

## Upcoming Events

- 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 QRP Call — August 17


- LTCH Quality Reporting Program Refresher Training Webinar — August 22
- CMS National Provider Enrollment Conference — September 6 and 7

## Medicare Learning Network Publications & Multimedia

- Quality Payment Program 2017 MIPS: Improvement Activities Performance Category Web-Based Training Course — New
- Provider/Supplier Enrollment Call: Audio Recording and Transcript — New
- Medicare Part B Immunization Billing Educational Tool — Reminder



### 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.

# MLN Connects® for August 3, 2017

*MLN Connects® for August 3, 2017*
*View this edition as a PDF*

## News & Announcements

- CMS Updates Medicare Payment Rates, Quality Reporting Requirements
- Hospice Benefit: FY 2018 Updates to the Wage Index and Payment Rates
- IRFs: Final FY 2018 Payment and Policy Changes
- SNFs: Final FY 2018 Payment and Policy Changes
- SNF Quality Reporting Program: Reconsideration Period Ends August 13
- Antipsychotic Drug use in Nursing Homes: Trend Update
- Vaccines are Not Just for Kids

## Provider Compliance

- Reporting Changes in Ownership

## Claims, Pricers & Codes

- ICD-10 GEMS for 2018 Available

## Upcoming Events

- SNF Quality Reporting Program: Review and Correct Reports Refresher
- Training Webinar — August 7
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
- CMS National Provider Enrollment Conference — September 6 and 7
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7
- Comparative Billing Report on IPPE/AWV Webinar — September 13

## Medicare Learning Network Publications & Multimedia

- Medicare Part B Immunization Billing Educational Tool — Revised
- The ABCs of the Annual Wellness Visit Educational Tool — Reminder



# MLN Connects® for August 10, 2017

*MLN Connects® for August 10, 2017*
*View this edition as a PDF*

## News & Announcements

- Medicare Card: Webpage Updates
- IRF Quality Reporting Program: Reconsideration Period Ends August 17
- LTCH Quality Reporting Program: Reconsideration Period Ends August 17
- Hospice Quality Reporting Program: Reconsideration Period Ends August 17
- EHR Incentive Program Hardship Exception Application Due by October 1
- Hospitals: Submit Meaningful Use Data to the HQR via the QualityNet Secure Portal in 2018
- Chronic Care Management: New Connected Care Videos
- Medicare Fee-For-Service Beneficiary Selection of a Primary Clinician
- Home Health Quality Reporting Program: OASIS-C2 2018 Guidance Manual Available
- Quality Payment Program Hardship Exception Application for 2017 Transition Year Open
- Quality Payment Program: Explanation of Special Status Calculation — Correction


## Provider Compliance

- Home Health Care: Proper Certification Required

## Claims, Pricers & Codes

- July 2017 OPPS Pricer File
- Part B Billing for Certain New Biosimilar Biological Products before the Modifier is Implemented

## Upcoming Events

- IRF Quality Reporting Program Refresher Training Webinar – August 15
- Medicare Diabetes Prevention Program Model Expansion Listening Session – August 16

See **MLN CONNECTS®**, next page

# MLN Connects® for August 17, 2017

*MLN Connects® for August 17, 2017*

*View this edition as a PDF*

## News & Announcements

- CMS Releases Hospice Compare Website to Improve Consumer Experiences, Empower Patients
- Proposed Changes to Comprehensive Care for Joint Replacement Model, Cancellation of Other Models
- CMS Releases Updated Data on Medicare Hospice Utilization and Payment
- SNF Quality Reporting Program Web-based Training Module Available
- Beneficiary Notices: Large Print Forms Available

## Provider Compliance

- Inpatient Skilled Nursing Facility Denials

## Claims, Pricers & Codes

- 2018 ICD-10-CM Coding Guidelines and Conversion Table Available

## Upcoming Events

- IMPACT Act: Medicare Spending Per Beneficiary Measures Call – September 6
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call – September 7

## Medicare Learning Network Publications & Multimedia

- Care Management Listening Session: Audio Recording and Transcript – New
- Medicare Parts A & B Appeals Process Booklet – Revised
- DMEPOS Information for Pharmacies Fact Sheet – Revised
- DMEPOS Accreditation Fact Sheet – Revised

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## MLN Connects®

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- Quality Payment Program Year 2 NPRM Virtual Office Hours Session – August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call – August 17
- LTCH Quality Reporting Program Refresher Training Webinar – August 22
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call – September 7

### Medicare Learning Network Publications & Multimedia

- August 2017 Catalog Available
- Quality Payment Program 2017: MIPS Quality Performance Category Web-Based Training Course – New
- Long-Term Care Call: Audio Recording and Transcript– New
- ESRD Listening Session: Audio Recording and Transcript – New
- Medicare Secondary Payer Web-Based Training Course – Revised
- Medicare Secondary Payer Booklet – Revised

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## 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