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

In this issue

Hurricane Irma and Medicare disaster-related US Virgin Islands, Puerto Rico, and Florida claims

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida who were affected by Hurricane Irma.

Provider information available

On September 5, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida. Also on September 6, 2017, for the United States Virgin Islands and commonwealth of Puerto Rico and September 7, 2017, for the state of Florida, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 5, 2017, for the United States Virgin Islands and commonwealth of Puerto Rico, and retroactive to September 4, 2017, for the state of Florida.

On September 7, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted counties and geographical areas of the United States Virgin Islands, commonwealth of Puerto Rico and state of Florida. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

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

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

Processing Issues

Claims rejecting in error with CWF reason codes U6816, U6817, and U6818

Issue

First Coast has identified Part A claims rejecting in error with common working file (CWF) reason codes U6816, U6817, and U6818 when Part A claims are billed with the applicable CARC codes listed in change request (CR) 8984 and CR 9009 which permits a residual payment if the services billed are covered and payable by Medicare.

Resolution

The Fiscal Intermediary Standard System (FISS) and the Centers for Medicare & Medicaid Services (CMS) are aware of this issue and are currently working on a resolution.

Status/date resolved

Open

Provider action

There is no provider action.

Current processing issues

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

Rejection of claims with CC DR or modifier CR

Issue

Providers are reporting occurrence span code (OSC) 70 with a date range 30 days or more before the skilled nursing facility (SNF) admission date (receiving reason code 11503) on claims with condition code DR or modifier CR.

Resolution

Providers should not report OSC 70 on claims billed with CC DR or modifier CR. See *1135 waiver FAQ document* SNF section, question 1135T-4.

Status/date resolved

Guidelines were established in 2011.

Provider action

Remove the OSC 70 when reporting CC DR or modifier CR.

Current processing issues

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

General Information

Provider enrollment relief for areas affected by Hurricane Irma

Effective September 13, 2017, and remaining in effect for a period of 180 days, First Coast implemented provider enrollment relief for providers in Florida, U.S. Virgin Islands, and Puerto Rico. During this period, we will:

- Refrain from mailing any revalidation letters, including subsequent revalidation letters (i.e., payment hold and deactivation letters due to non-response to revalidation or revalidation development).
- Refrain from placing providers/suppliers on payment hold and deactivating providers/suppliers who fail to respond to a revalidation request.
- Refrain from mailing any new fingerprint-based background check letters. Denial or revocation of providers/suppliers due to non-response to fingerprints shall also be held.
- Extend the 30-day development response requirement to 90 days, if development is needed.
- Continue to order site visits. However, the national site visit contractor will not perform site visits in the impacted area until the major disaster declaration is lifted.
- Continue to require that all changes, temporary or otherwise, be submitted via the appropriate CMS-855 application.

First Coast will communicate any changes to this effective date currently in place so stay tuned to *eNews*.

For additional assistance, visit our dedicated *disaster information* page.

Administrative relief for areas affected by Hurricane Harvey

If you were affected by Hurricane Harvey and are unable to file a timely claims appeal, please contact your Medicare administrative contractor (*http://go.usa.gov/cuX3x*).

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Providers do not need to apply for an individual waiver if blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional blanket waiver requests are being reviewed. The most current waiver information can be found under *Administrative Actions* at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. This article will be updated as additional waivers are approved. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands, and commonwealth of Puerto Rico from September 5, 2017, and the state of Florida from September 4, 2017, for the duration of the emergency. In accordance with CR 6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. The most current information can be found at *https://www.cms.gov/emergency*. Medicare FFS questions & answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida . These Q&As are displayed in two files:

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida.
- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 6, 2017, for the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a. Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b. Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities

Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to

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OASIS transmission. (Blanket waiver for all impacted agencies)

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Irma, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to Hurricane Irma. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital – this information added September 19, 2017

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital – this information added September 19, 2017

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

Emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Irma, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

For more information refer to the *DMEPOS for Medicare Beneficiaries Impacted by an Emergency or Disaste*r fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Facilities quality reporting – this information added September 19, 2017

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Florida counties, Puerto Rico municipios, or U.S. Virgin Islands county-equivalents, all of which have been designated by the *Federal Emergency Management Agency (FEMA)* as a major disaster county, municipio, or county-equivalent. Further information can be found in the memo on applicability of reporting requirements to certain providers in the *Downloads* section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*.

Appeal administrative relief for areas affected by Hurricane Irma

If you were affected by Hurricane Irma and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

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Hurricane Irma and Medicare disaster-related South Carolina and Georgia claims

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the states of South Carolina and Georgia who were affected by Hurricane Irma.

Provider information available

On September 7, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the state of South Carolina. On September 8, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the state of Georgia. Also on September 8, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the states of South Carolina and Georgia and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 6, 2017, for the state of South Carolina and retroactive to September 7, 2017, for the state of Georgia.

On September 8, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the states of South Carolina and Georgia, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted counties and geographical areas of the states of South Carolina and Georgia. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

The most current waiver information can be found under *Administrative Actions* at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. See the *Background* section of this article for more details.

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Replacement prescription fills – this information added September 19, 2017

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional information

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

The Centers for Disease Control and Prevention released *ICD-10-CM coding advice* to report healthcare encounters in the hurricane aftermath.

Providers may also want to view the *Survey and Certification Frequently Asked Questions* at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
September 19, 2017	The article was revised to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital, to add information on replacement prescription fills of covered Part B drugs, and information on facilities quality reporting. All other information remains the same. All other information remains the same.
September 8, 2017	Initial article released.

MLN Matters® Number: SE17022 *Revised*
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Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of South Carolina from September 6, 2017, and the state of Georgia from September 7, 2017, for the duration of the emergency. In accordance with CR 6451, use of the DR condition code and the CR modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. The most current information can be found at *https://www.cms.gov/emergency*. Medicare FFS questions & answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the states of South Carolina and Georgia. These Q&As are displayed in two files:

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the states of South Carolina and Georgia.
- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 6, 2017, for the state South Carolina and September 7, 2017, for the state of Georgia.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a. Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b. Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **the states of South Carolina and Georgia**. Individual facilities do not need to apply for the following approved blanket waivers:

Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in the states of South Carolina and Georgia in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission. (Blanket waiver for all impacted agencies)

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Irma, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to Hurricane Irma. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital – this information added September 19, 2017

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in

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an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital – this information added September 19, 2017

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

Durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Irma, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

For more information refer to the *DMEPOS for Medicare Beneficiaries Impacted by an Emergency or Disaster* fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Appeal administrative relief for areas affected by Hurricane Irma

If you were affected by Hurricane Irma and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

Replacement prescription fills – this information added September 19, 2017

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional information

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

The Centers for Disease Control and Prevention released *ICD-10-CM coding advice* to report healthcare encounters in the hurricane aftermath.

Providers may also want to view the *Survey and Certification Frequently Asked Questions* at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
September 19, 2017	The article was revised to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital and to add information on replacement prescription fills of covered Part B drugs. All other information remains the same.
September 11, 2017	Initial article released.

MLN Matters® Number: SE17024 *Revised*
Article Release Date: September 19, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Appeals and overpayment requests for providers/suppliers affected by a natural disaster

When filing an appeal or responding to an overpayment request with First Coast Service Options, the following information is required:

- Patient name
- Medicare ID number
- The specific service(s) and/or item(s) for which the redetermination is being requested
- Date of service
- The name and signature of the party or the representative of the party

If you were affected by Hurricanes Irma, Harvey, or Maria, and are unable to file a timely claims appeal, you can contact First Coast in writing to request an extension.

Likewise, if you are unable to respond timely to a request for overpayment or need to appeal an overpayment request, you should contact First Coast in writing.

All written requests for extensions of an appeal or overpayment request extensions should include the following verbiage in the subject line: "Natural Disaster exception." If the information above is not available or you are otherwise unable to submit a written request, you are encouraged to call the Provider Contact Center customer service for additional information at:

Florida/U.S. Virgin Islands: (888) 664-4112 (Part A) or (866) 454-9007 (Part B)

Puerto Rico: (877) 908-8433 (Part A) or (877) 715-1921 (Part B)

Providers affected by Hurricanes Harvey and Irma

In response to the devastation of Hurricanes Harvey and Irma, the Centers for Medicare & Medicaid Services (CMS) are granting widespread administrative relief. This administrative relief is in addition to any individual needs required on a case by case basis. First Coast Service Options Inc. (First Coast) will work with these providers to ensure payment is received for covered services.

Widespread administrative relief will include the suspension of additional documentation requests (ADRs) related to medical review editing for a period of 30 days, ending October 11, 2017. Additionally, providers will be automatically granted 30 additional days to respond to any documentation request that may have already been requested during this 30-day period.

If you are unable to submit records due to a disaster related situation, you may attach a letter to the ADR explaining your situation. This will ensure that your claim is handled appropriately. There are some billing situations that may require an explanation or a description of the service billed (e.g., unlisted Healthcare Common Procedure Coding System [HCPCS] codes, modifiers, etc.). If you are including a letter to indicate that you are unable to provide the medical documentation you must provide a contact person as well a telephone number in the event that clarification is needed for claims processing. You may follow your normal process for responding. This information may be found within your ADR letter.

Extensions for Part A providers affected by hurricanes Harvey and Irma

First Coast Service Options' (First Coast) Provider Audit and Reimbursement Department (PARD) announces extensions for resubmitting certain Worksheet S-10 data and submitting cost reports to help alleviate provider burden.

Worksheet S-10 data deadline

For hospitals in Florida, Puerto Rico, Texas, Louisiana, Georgia, and South Carolina, the Centers for Medicare & Medicaid Services (CMS) has modified the September 30, 2017, deadline to resubmit certain Worksheet S-10 data as described in the FY 2018 Inpatient Prospective Payment/ Long-Term Care Hospital Prospective Payment System final rule (82 FR 38208, August 14, 2017). For revisions to be considered, First Coast must receive the amended FY 2014 and FY 2015 cost reports due to revised or initial submissions of Worksheet S-10 by October 31, 2017.

If First Coast has already issued the Notice of Program Reimbursement (NPR) for the cost report(s), submit Worksheet S-10 support documentation to the First Coast audit manager for your facility by October 31, 2017.

If you are submitting an amended cost report, please follow the normal process for filing amended and original cost reports. As soon as you determine that an amended cost report will be filed, please notify the First Coast audit manager for your facility so they can halt the issuance of the NPR.

If you encounter difficulties meeting this extended deadline of October 31, 2017, please contact First Coast Reimbursement Manager Estarlina Ortiz at *Estarlina.Ortiz@fcso.com* or contact the First Coast audit manager assigned to your facility. An additional extension may be granted if CMS determines it's warranted.

Cost report due date

First Coast will also extend the due date for cost reports to providers affected by hurricanes Harvey and Irma to allow additional time to submit them without having payments interrupted. To request an extension, providers should contact First Coast Reimbursement Manager Estarlina Ortiz at *Estarlina.Ortiz@fcso.com* as soon as they determine an extension is needed.

For additional assistance, visit our *disaster information* page.

Hurricane Maria and Medicare disaster-related US Virgin Islands and Puerto Rico claims

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands and commonwealth of Puerto Rico who were affected by Hurricane Maria.

Provider information available

On September 18, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Maria, an emergency exists in the United States Virgin Islands and the commonwealth of Puerto Rico. Also on September 19, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the United States Virgin Islands and the commonwealth of Puerto Rico and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 16, 2017, for the United States Virgin Islands and retroactive to September 17, 2017, for the commonwealth of Puerto Rico.

On September 19, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands and the commonwealth of Puerto Rico, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted counties and geographical areas of the United States Virgin Islands and the commonwealth of Puerto Rico. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

The most current waiver information can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands from September 16, 2017, and the commonwealth of Puerto Rico from September 17, 2017, for the duration of the emergency. In accordance with CR 6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. The most current information can be found at *https://www.cms.gov/emergency*. Medicare FFS questions & answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands and the commonwealth of Puerto Rico. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable **without** any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands and the commonwealth of Puerto Rico.
- Another file addresses policies and procedures that are applicable **only with** approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 16, 2017, for the United States Virgin Islands and the commonwealth of Puerto Rico.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a. Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b. Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida**. Individual facilities do not need to apply for the following

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approved blanket waivers:

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in the United States Virgin Islands and the commonwealth of Puerto Rico in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission. (Blanket waiver for all impacted agencies)

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Maria, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to Hurricane Maria. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Maria, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of Hurricane Maria, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

Emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Maria, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

For more information refer to the *DMEPOS for Medicare Beneficiaries Impacted by an Emergency or Disaste*r fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Appeal administrative relief for areas affected by Hurricane Maria

If you were affected by Hurricane Maria and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

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Hurricane Harvey and Medicare disaster-related Texas claims

Provider types affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the state of Texas who were affected by Hurricane Harvey.

Provider information available

On August 26, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Harvey, a major disaster exists in the state of Texas, retroactive to August 25, 2017. Also August 26, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the state of Texas and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 25, 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) has issued several blanket waivers in the impacted counties and geographical areas of Texas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional blanket waiver requests are being reviewed.

The most current waiver information can be found under *Administrative Actions* at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. This article will be updated as additional waivers are approved. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of Texas from August 25, 2017, for the duration of the emergency. In accordance with CR 6451, use of the DR condition code and the CR modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. The most current information can be found at *https://www.cms.gov/emergency*. Medicare FFS questions & answers (Q&As) posted in the downloads section at the bottom of the *Emergency Response and Recovery* webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the state of Texas. These Q&As are displayed in two files:
   - The first listed file addresses policies and procedures that are applicable without any Section

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Replacement prescription fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional information

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

The Centers for Disease Control and Prevention released *ICD-10-CM coding advice* to report healthcare encounters in the hurricane aftermath.

Providers may also want to view the *Survey and Certification Frequently Asked Questions* at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
September 21, 2017	Initial article released.

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Effective Date: N/A
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- 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Texas.
- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 25, 2017, for Texas.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information revised.

a) Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b) Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **Texas**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Harvey in the state of Texas in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission. (Blanket waiver for all impacted agencies)
- Home health agencies should monitor information posted at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html* under *Administrative Actions* for updates on waivers.

Critical access hospitals

- This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

- CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Harvey, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the hurricane/tropical storm Harvey. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Emergency DMEPOS for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Harvey, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable as a result of the hurricane.

For more information refer to the *Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster* fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Application deadline extended for reclassifications submission to MGCRB

In accordance with *Waiver or Modification of Requirements* under Section 1135 of the Social Security Act issued August 26, 2017, by Secretary Price, CMS is modifying the September 1, 2017, deadline for applications for FY 2019 reclassifications to be submitted to the Medicare Geographic Classification Review Board (MGCRB). CMS is currently granting a 31-day extension to the deadline at § 412.256(a)(2) for the state of Texas. Applications for FY 2019 reclassifications from hospitals in these areas must be received by the MGCRB not later than October 2, 2017.

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Deadline extended for IPPS wage index requests

Regarding the FY 2019 wage index, CMS is modifying the September 1, 2017, deadline specified in the FY 2019 hospital wage index development time table for these hospitals to request revisions to and provide documentation for their FY 2015 Worksheet S-3 wage data and CY 2016 occupational mix data, as included in the May 18, 2017, and July 12, 2017, preliminary PUFs, respectively. CMS is currently granting an extension for hospitals in the state of Texas until October 2, 2017. MACs must receive the revision requests and supporting documentation by this date. If hospitals encounter difficulty meeting this extended deadline of October 2, 2017, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Facilities quality reporting

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Texas counties, all of which have been designated by the *Federal Emergency Management Agency (FEMA)* as a major disaster county. Further information can be found in the memo on applicability of reporting requirements to certain providers in the Downloads section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*.

Medicare-dependent small, rural hospitals (MDHs)

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017 deadline for Medicare-dependent small, rural hospitals (MDHs) to apply for sole community hospital (SCH) status in advance of the expiration of the MDH program with an effective date of an approval of SCH status that is the day following the expiration date of the MDH program (that is, September 30, 2017 under current law). CMS is currently granting a 31-day extension to the deadline at § 412.92(b)(2)(v) for the state of Texas. If a hospital located in these areas that is classified as an MDH applies for classification as an SCH under the provisions of § 412.92(b)(2)(v), and that hospital's SCH status is approved, the effective date of approval of SCH status will be the day following the expiration date of the MDH program if such hospital applies for classification as a SCH not later than October 2, 2017.

Low-volume hospital

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017, deadline for hospitals to make a written request for low-volume hospital status that is received by its Medicare administrative contractor (MAC) in order for the 25 percent low-volume hospital payment adjustment to be applied to payments for its discharges beginning on or after the start of the federal fiscal year (FY) 2018. CMS is currently granting a 31-day extension to the deadline established in the FY 2018 Inpatient Prospective Payment System (IPPS)/LTCH PPS Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (82 FR 38186) for the state of Texas. Requests for low-volume hospital status for FY 2018 from a hospital located in these areas must be received by the MAC no later than October 2, 2017, in order for the low-volume hospital payment adjustment to be applied beginning with the start of the FY 2018 (that is, for discharges occurring on or after October 1, 2017).

Appeal administrative relief for areas affected by Hurricane Harvey

If you were affected by Hurricane Harvey and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

Replacement prescription fills – this information added September 19, 2017

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Moratoria on Part B non-emergency ambulance suppliers

CMS has authority under 42 C.F.R. § 424.570(d) to lift a moratorium at any time if the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act. On August 25, 2017, the President of the United States signed the Presidential Disaster Declaration for several counties in the state of Texas. As a result of the President's declaration CMS has carefully reviewed the potential impact of continued moratorium in Texas and is lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas in order to aid in the disaster response. This lifting applies to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) and became effective September 1, 2017. CMS will also publish a document in the *Federal Register* to announce that the moratoria on Part B non-emergency ambulance suppliers has been lifted. Providers and suppliers that were unable to enroll because of the moratorium will be designated to CMS' high screening level under 42 CFR § 424.518(c)(3)(iii) to the extent these providers and suppliers enroll in Medicare in the future.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/*

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Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf.

Additional information

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

The Centers for Disease Control and Prevention released ICD-10-CM coding advice to report healthcare encounters in the hurricane aftermath.

Providers may also want to view the *Survey and Certification Frequently Asked Questions* at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
September 19, 2017	The article was revised to include information about replacement prescription fills of covered Part B drugs. All other information remains the same.
September 7, 2017	The article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.
September 5, 2017	The article was revised September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units and lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas. In addition, information has been added to the *Facilities quality reporting* Section and the second paragraph of the *Provider information available* section is modified to clarify that waivers prevent gaps in access to care.
September 1, 2017	The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was added. All other information remained the same.
August 31, 2017	Initial article released.

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Tropical storm Harvey and Medicare disaster-related Louisiana claims

Provider types affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the state of Louisiana who were affected by tropical storm Harvey.

Provider information available

On August 28, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of tropical storm Harvey, a major disaster exists in the state of Louisiana, retroactive to August 27, 2017. Also on August 28, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the state of Louisiana and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 27, 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) has issued several blanket waivers in the impacted counties and geographical areas of Louisiana. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional blanket waiver requests are being reviewed. The most current waiver information can be found under *Administrative Actions* at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. This article will be updated as additional waivers are approved. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declarations, CMS has instructed the MACs as follows:

1) Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of Louisiana from August 27, 2017, for the duration of the emergency. In accordance with CR 6451, use of the DR condition code and the CR modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2) The most current information can be found at *https://www.cms.gov/emergency*. Medicare FFS questions & answers (Q&As) posted in the *Downloads* section at the bottom of the *Emergency Response and Recovery* webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the state of Louisiana. These Q&As are displayed in two files:
   - The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Louisiana.
   - The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 27, 2017, for Louisiana.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information revised.

a) Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b) Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **Louisiana**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of tropical storm Harvey in the state of Louisiana in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for

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- minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission. (Blanket waiver for all impacted agencies)
- Home health agencies should monitor information posted at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html* under *Administrative Actions* for updates on waivers.

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

- CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Harvey, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the hurricane/tropical storm Harvey. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Emergency DMEPOS for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Harvey, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable as a result of the hurricane.

For more information refer to the *Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster* fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Application deadline extended for reclassifications submission to MGCRB

In accordance with Waiver or Modification of Requirements under Section 1135 of the Social Security Act issued August 28, 2017, by Secretary Price, CMS is modifying the September 1, 2017, deadline for applications for FY 2019 reclassifications to be submitted to the Medicare Geographic Classification Review Board (MGCRB). CMS is currently granting a 31-day extension to the deadline at § 412.256(a)(2) for the state of Louisiana. Applications for FY 2019 reclassifications from hospitals in these areas must be received by the MGCRB not later than October 2, 2017.

Deadline extended for IPPS wage index requests

Regarding the FY 2019 wage index, CMS is modifying the September 1, 2017, deadline specified in the FY 2019 hospital wage index development time table for these hospitals to request revisions to and provide documentation for their FY 2015 Worksheet S-3 wage data and 2016 occupational mix data, as included in the May 18, 2017, and July 12, 2017, preliminary PUFs, respectively. CMS is currently granting an extension for hospitals in the state of Louisiana until October 2, 2017. MACs must receive the revision requests and supporting documentation by this date. If hospitals encounter difficulty meeting this extended deadline of October 2, 2017, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Facilities quality reporting

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Louisiana parishes, all of which have been designated by the *Federal Emergency Management Agency (FEMA)* as a major disaster county. Further information can be found in the memo on applicability of reporting requirements to certain providers in the *Downloads* section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*.

Medicare-dependent small, rural hospitals (MDHs)

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 28, 2017, by Secretary Price, CMS is modifying the September 1, 2017, deadline for Medicare-dependent small, rural hospitals (MDHs) to apply for sole community hospital (SCH) status in advance of the expiration of the MDH program with an effective date of an approval of SCH status that is the day following the expiration date of the MDH program (that is, September 30, 2017, under current law). CMS is currently granting a 31-day extension to the deadline at § 412.92(b)(2)(v) for the state of Louisiana. If a hospital located in these areas that is classified as an MDH applies for classification as an SCH under the provisions of § 412.92(b)(2)(v), and that hospital's SCH status is approved, the effective

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date of approval of SCH status will be the day following the expiration date of the MDH program if such hospital applies for classification as a SCH not later than October 2, 2017.

Low-volume hospital

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 28, 2017, by Secretary Price, CMS is modifying the September 1, 2017, deadline for hospitals to make a written request for low-volume hospital status that is received by its Medicare administrative contractor (MAC) in order for the 25-percent low-volume hospital payment adjustment to be applied to payments for its discharges beginning on or after the start of the federal fiscal year (FY) 2018. CMS is currently granting a 31-day extension to the deadline established in the FY 2018 Inpatient Prospective Payment System (IPPS)/LTCH PPS Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (82 FR 38186) for the state of Louisiana. Requests for low-volume hospital status for FY 2018 from a hospital located in these areas must be received by the MAC no later than October 2, 2017, in order for the low-volume hospital payment adjustment to be applied beginning with the start of the FY 2018 (that is, for discharges occurring on or after October 1, 2017).

Appeal administrative relief for areas affected by Tropical Storm Harvey

If you were affected by Tropical Storm Harvey and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

Replacement prescription fills – this information added September 19, 2017

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional information

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

The Centers for Disease Control and Prevention released ICD-10-CM coding advice to report healthcare encounters in the hurricane aftermath.

Providers may also want to view the *Survey and Certification Frequently Asked Questions* at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
September 19, 2017	The article was revised to include information regarding replacement prescription fills of covered Part B drugs. All other information remains the same.
September 7, 2017	The article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.
September 5, 2017	The article was revised September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units. In addition, information has been added to the *Facilities quality reporting* section and the second paragraph of the *Provider information available* section is modified to clarify that waivers prevent gaps in access to care.
September 1, 2017	The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was added. All other information remained the same.
August 31, 2017	Initial article released.

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Billing in MSP liability insurance situations

Provider type affected

This *MLN Matters*® article is intended for all providers, physicians, and other suppliers who bill in a situation where liability insurance (including self-insurance) is a consideration. The article is of particular importance for those who elect not to file the claim with Medicare, and instead seek payment for their services from a Medicare beneficiary's liability insurance (including self-insurance) claim.

Provider action needed

This article is based on information received from Medicare beneficiaries, their legal counsel and other entities that assist these individuals, indicating that providers, physicians, and other suppliers that elect to seek payment from the beneficiary's liability insurance claim instead of submitting the claim for items or services to Medicare have not generally billed in accordance with the instructions provided or referenced in this article. The FAQs in this article are intended to remind providers, physicians, and other suppliers of the fundamental guidance governing billing where liability insurance (including self-insurance) is involved. Please review your billing practices to be sure they are in line with the information below.

Background

Liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits are primary payers to Medicare. However, CMS' regulations and policy for liability insurance billing are distinct from those for no-fault insurance and workers' compensation benefits. Because the liability insurance billing rules are different and place distinct obligations on providers, physicians, and other suppliers (including termination of liens tied to the expiration of Medicare's timely filing requirements), it is important that these rules be reviewed in detail.

The options when seeking payment from the liability insurance, and the obligations and restrictions that accompany them, are discussed with more specificity in the Internet-only *Medicare Secondary Payer Manual* (Pub 100-05), Chapter 2, Section 40.2 found at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c02.pdf*. *See also*, *MLN Matters*® article MM7355 "Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault, and Workers' Compensation (WC) Medicare Secondary Payer (MSP) Claims". This article is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7355.pdf*. (Although not the subject of this article, the instructions for situations involving no-fault insurance or workers' compensation benefits can be found in Chapter 3 of the *MSP Manual*.)

FAQs for liability insurance (including self-insurance) billing

Q1. What are the "promptly period" rules and do they apply when billing in situations involving liability insurance (including self-insurance)?

A1. The "promptly period" is 120 days after the earlier of: 1) the date the claim is filed with an insurer or a lien is filed against a potential liability settlement; or 2) the date the service was furnished or, in the case of inpatient hospital services, the date of discharge. The "promptly period" does apply even when a provider, physician, or other supplier is aware that liability insurance may end up indirectly funding the defendant's settlement. However, following expiration of the 120 days or during that time if it is demonstrated (for example, a bill/claim that had been submitted but not paid) that liability insurance will not pay during the promptly period, the provider, physician, or other supplier has an option (with certain limitations) to bill Medicare or maintain a claim/lien against the liability insurance/beneficiary's liability insurance settlement.

Q2. Who do I bill…Medicare or the liability insurance/beneficiary's liability insurance settlement? (I hear so many different things. My patient was in an accident and I need to know whether to bill Medicare or the patient. My other patient is suing some manufacturer, what do I do about my bill for services to this patient?)

A2. Once the "promptly period" has expired, with the exception of the special rule for Oregon (see below), the provider, physician, or other supplier may bill *either* Medicare or the liability insurer/beneficiary's liability insurance settlement *as long as the Medicare timely filing period has not expired.* Billing both Medicare and maintaining a claim against the liability insurance/beneficiary's liability insurance settlement is not permitted. Once Medicare has been billed, the provider, physician, or other supplier is limited to Medicare's approved amount or the limiting charge if the claim is non-assigned, even if they subsequently return any payment made by Medicare. Claims/liens against the liability insurance/beneficiary's liability settlement must be dropped once Medicare's timely filing period has expired. *See also* the Q's/A's below for more detail.

Q3. What is the Oregon rule?

A3. By court order, there are very specific alternative billing rules for Oregon. Generally speaking, the provider, physician, or other supplier may bill either Medicare or the liability insurance if the liability insurer pays within 120 days. *See* the MSP Manual (CMS Pub. 100-05), Chapter 2, Section 40.2 for specifics on the Oregon rule.

Q4. Do Medicare's timely filing rules still apply if the timely filing period expires while the provider, physician, or other supplier is waiting for the liability insurance payment/beneficiary's liability insurance

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settlement? (It's been three years and the patient's case still hasn't settled. Can I bill Medicare now?)

A4. The existence of a liability insurance or potential liability insurance situation does not change or extend Medicare's timely filing requirements. If Medicare is not billed within the applicable timely filing period, the claim will be denied. Additionally, see the information below regarding the requirement that claims/liens against the liability insurance/beneficiary's liability insurance settlement (with certain exceptions) be withdrawn once the timely filing period has expired.

Q5. How long can a claim/lien be maintained against the liability insurer/the beneficiary's liability insurance settlement? (Can I direct bill/maintain my lien once Medicare's timely filing period has expired?)

A5. CMS' liability insurance billing policy is that providers are required to drop their claims/liens and terminate all billing efforts to collect from a liability insurer or a beneficiary once the Medicare timely filing period expires, unless the liability insurance claim was paid or settled prior to the expiration of the Medicare timely filing period.

- All such claims/liens must be withdrawn (except for claims related to items or services not covered by Medicare and for Medicare deductibles and co-insurance) when the provider, physician, or other supplier bills Medicare or when Medicare's timely filing period has expired – whichever occurs first.
- If there is a settlement, judgment, award, or other payment before the timely filing period expires, the provider, physician, or supplier may maintain its claim/lien despite the expiration of the timely filing period.
- All such claims/liens are limited by state lien laws/requirements. The MSP provisions do not create lien rights when those rights do not exist under state law.
- Under the Oregon rule all such claims/liens must be withdrawn following the expiration of the applicable 120 day period.

Q6. How much can the provider, physician or other supplier bill the liability insurance/beneficiary's liability insurance settlement? (What if the beneficiary's case settled, but the amount was not large enough to pay everyone? What if Medicare and the attorney were paid, but because very little remained the attorney asked all the doctors and other providers to take reduced amounts; do we have to?; what about our bill?)

A6. Where Medicare has a recovery claim, Medicare's claim has the priority right of recovery. In general, the provider, physician, or other supplier:

- Is limited to the Medicare approved amount (limiting charge when non-assigned) once they have billed Medicare, even if they return any payment received from Medicare.
- May charge actual charges but is limited to the amount available from the settlement less applicable procurement costs (for example, attorney fees, other litigation costs).
- May only bill for non-covered services, or co-insurance and deductibles, if Medicare timely filing has expired before payment or settlement. (In this context, non-covered services are the program exclusions such as measuring of eye refractions or services rendered to family members. Medical necessity denials are not included and are not billable in the example.)
- May not collect from the beneficiary until the proceeds are available to the beneficiary.

Q7. What about physician and other suppliers who do not participate in Medicare and do not submit an assigned claim (and would not be required to submit an assigned claim if they submitted a claim to Medicare) – what can they pursue?

A7. Such physicians and other suppliers can pursue liability insurance, but the amount may not exceed the limiting charge.

Q8. Are there risks involved in deciding whether to pursue the liability insurance vs. billing Medicare once the promptly period has expired?

A8. Providers, physicians, and other suppliers who do not file a Medicare claim once the "promptly period" has expired (and before timely filing has expired) run the risk that insurance proceeds will not be available or may be less than Medicare's payment would have been if Medicare had been billed. They also run the risk that they will be limited to billing for co-insurance and deductibles if there is no payment or settlement before Medicare's timely filing expires.

Q9. Are there additional rules if a patient receives both Medicare and Medicaid or other benefits?

A9. If the individual receives assistance from the state, additional regulations govern provider billing. If a Medicare beneficiary received Medicaid benefits at the time the services were rendered, providers should contact their state Medicaid office to obtain the state's policy on provider billing.

Q10. What if the items or services in question are not covered by Medicare?

A10. If the items or services rendered are services that are not covered by the Medicare program, providers, physicians, and other suppliers may charge and collect actual charges without regard to whether the proceeds of the liability insurance are available to the beneficiary. (In this context, non-covered services are the program

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Accepting payment from patients with a Medicare set-aside arrangement

Provider type affected

This *MLN Matters*® article is intended for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a workers' compensation Medicare set-aside arrangement (WCMSA), a liability insurance Medicare set-aside arrangement (LMSA), or a no-fault insurance Medicare set-aside arrangement (NFMSA).

What you need to know

This article is based on information received from Medicare beneficiaries, their legal counsel, and other entities that assist these individuals indicating that physicians, providers, and other suppliers are often reluctant to accept payment directly from Medicare beneficiaries who state they have a Medicare set-aside arrangement (MSA) and must pay for their services themselves. This article explains what a MSA is and explains why it is appropriate to accept payment from a patient that has a funded MSA.

Please review your billing practices to be sure they are in line with the information provided.

Background

Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made, or can reasonably be expected to be made promptly, under liability insurance (including self-insurance), no-fault insurance, or workers' compensation (WC). (See Section 1862(b)(2)(A) of the Social Security Act, cited in the U.S. code at 42 U.S.C. § 1395y(b)(2)(A)(i)). When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Whether those services are associated with a liability insurance, no-fault insurance, or WC situation, Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

Reminders:

- Liability insurance (including self-insurance) includes all types of liability insurance. No-fault insurance is *not* limited to automobile no-fault. It is sometimes referred to as "med-pay" or "personal injury protection/PIP".
- WC includes a WC law or plan of the United States or any state. It also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands as well as to the Federal WC plans provided under the Federal Employees Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act (and its extensions).

(*See also* 42 C.F.R. §§ 411.40, 411.43, and 411.50.)

A MSA is a financial arrangement that allocates a portion of a settlement, judgment, award, or other payment to pay for future medical services. The law mandates protection of the Medicare trust funds but does not mandate a MSA as the vehicle used for that purpose. MSAs are the most frequently used formal method of preserving those funds for the Medicare beneficiary to pay for future items or services which are otherwise covered and reimbursable by Medicare and which are related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing. These funds must be exhausted before

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exclusions such as measuring of eye refractions or services rendered to family members. Medical necessity denials are not included and are not billable in the example.)

Additional information

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

Document history

Date of change	Description
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Medicare will pay for treatment related to the claimed injury, illness, or disease.

Medicare beneficiaries are advised that before receiving treatment for services to be paid by their MSA, they should advise their health care provider about the existence of the MSA. They are also notified that their health care providers should bill them directly, and that they should pay those charges out of the MSA **if**:

- The treatment or prescription is for the liability insurance, no-fault insurance or workers' compensation injury/illness/accident; AND
- The treatment or prescription is something Medicare would cover.

For WC, the Centers for Medicare & Medicaid Services (CMS) has a formal process that allows for the review of proposed MSA amounts if specific criteria are met. While CMS recommends use of this process, proposed WCMSA amounts are not required to be submitted to CMS for review. CMS utilizes its workers' compensation review contractor for the review of voluntarily- submitted proposed WCMSA amounts. CMS currently has no such review process for proposed LMSA amounts or proposed NFMSA amounts.

The obligation to protect the Medicare trust funds exists regardless of whether or not there is a formal CMS approved MSA amount. Because the CMS review process is voluntary for WCMSA amounts, and there is no formal process for reviewing proposed LMSA or NFMSA amounts, a Medicare beneficiary may or may not have documentation they can provide the physician, provider, or supplier from Medicare approving a Medicare set-aside amount.

Provider action needed

Where a patient who is a Medicare beneficiary:

- States that he/she was involved in a liability insurance, no-fault insurance, or workers' compensation situation;
- States that he/she is required to use funds from the settlement, judgment, award, or other payment to pay for the items or services related to what was claimed

or which the settlement, judgment, award, or other payment;

It is appropriate for you to document your records with that information and accept payment directly from the patient for such services.

Additional information

If you have any questions, please contact your Medicare administrative contractor (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
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Effective Date: N/A
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Prohibition on billing dually eligible individuals enrolled in the QMB program

***Note**: This article was revised August 23, 2017, to highlight upcoming system changes that identify the qualified Medicare beneficiary (QMB) status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt. This information was previously published in the May 2017 Medicare A Connection, pages 5-7.*

Provider types affected

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

Provider action needed

This special edition *MLN Matters*® article from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers and suppliers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing.** Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Look for new information and messages in CMS' HIPAA eligibility transaction system (HETS) and the provider remittance advice (RA) to identify patients' QMB status and exemption from cost-sharing prior to billing. If you are an MA provider, contact the MA plan for more information about verifying the QMB status of plan members.

Implement key measures to ensure compliance with QMB billing requirements. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the states in which you practice. Refer to the *Background* and *Additional information* sections for further details and important steps to promote compliance.

Background

All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must refrain from charging individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill state Medicaid programs for these costs, but states can limit Medicare cost-sharing payments under certain circumstances.

Billing of QMBs is prohibited by federal law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a state Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program. See the chart at the end of this article for more information about the QMB benefit.

Providers and suppliers may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by federal law, States can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

Note that certain types of providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt discussed in Chapter 3 of the *Provider Reimbursement Manual* (Pub.15-1).

Refer to the *Important Reminders concerning QMB billing requirements* section for key policy clarifications.

Inappropriate billing of QMB individuals persists

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

Ways to promote compliance with QMB billing rules

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

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

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

Ways to improve processes related to QMBs

Take the following steps to ensure compliance with QMB billing prohibitions:

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.
   - Beginning November 4, 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS' HETS to verify a patient's QMB status and exemption from cost-sharing charges. For more information on HETS, see *https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html*.
   - Starting October 3, 2017, original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions from the Medicare provider RA, which will contain new notifications and information about a patient's QMB status. Refer to *Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System* for more information about these improvements.
   - MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.
   - Providers and suppliers may also verify a patient's QMB status through state online Medicaid eligibility systems or other documentation, including Medicaid identification cards and documents issued by the state proving the patient is enrolled in the QMB program.
2. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid.
3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the states in which you operate. Different processes may apply to original Medicare and MA services provided to individuals enrolled in the QMB program. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.
   - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.
   - Understand the processes you need to follow to request payment for Medicare cost-sharing amounts if they are owed by your state. You may need to complete a state provider registration process and be entered into the state payment system to bill the state.

Important Reminders Concerning QMB Billing Requirements

Be aware of the following policy clarifications on QMB billing requirements:

1. All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must abide by the billing prohibitions.
2. Individuals enrolled in the QMB program retain their protection from billing when they cross state lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is provided by a different state than the state in which care is rendered.
3. Note that individuals enrolled in QMB cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the state Medicaid Manual, which is no longer in effect.

QMB eligibility and benefits (see page 25)

Additional information

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

Document history

Date of change	Description
August 23, 2017	The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.

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Date of change	Description
May 12, 2017	This article was revised May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.
January 12, 2017	This article was revised to add a reference to *MLN Matters*® article *MM9817*, which instructs Medicare administrative contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.
February 4, 2016	The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under *Important Clarifications Concerning QMB Balance Billing Law*.
February 1, 2016	The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table.
March 28, 2014	The article was revised to change the name of the coordination of benefits contractor (COBC) to BCRC.

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QMB eligibility and benefits

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

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

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

A physician's guide to Medicare Part D medication therapy management programs

***Note**: This article was revised August 24, 2017, to provide updated information, primarily in the new "Part D enhanced medication therapy management model" section. All other information is unchanged. This information was previously published in the October 2012 Medicare B Connection, pages 32-34.*

Provider type affected

This *MLN Matters*® special edition article about medication therapy management (MTM) services is intended for physicians, pharmacists, nurses, and other health care providers who treat Medicare beneficiaries with Part D coverage.

Provider action needed

This *MLN*® release is intended to make you aware of Medicare Part D MTM programs that will affect your patients, and introduce you to three MTM forms that your patients are likely to share with you.

Your patients may ask you if they would benefit from MTM services. If you have patients enrolled in Part D MTM programs, you may also be contacted by MTM providers who are required to monitor patients' medication therapies from all their health care providers. This may result in recommendations that are shared with you about unsafe or dangerous interactions and therapeutic alternatives. Your patients may also receive recommendations about how to use their medications properly.

MTM providers are important partners with you

MTM providers work with physicians to deliver the best medication therapy to patients and to coordinate their medication therapy across multiple practitioners. The latest clinical information is used by MTM providers when reviewing patients' medication therapy, such as updates to the Beers criteria for high-risk medications and revised monographs for old and new medications. MTM providers also listen to patients' concerns about their medications and may offer recommendations to physicians and patients to help achieve their goals of therapy. As always, physicians make the final decisions about changes in drug therapy.

When will MTM providers contact you?

Your patients enrolled in MTM may receive an interactive comprehensive medication review (CMR) any time during the year.

- The MTM provider may reach out to you in order to clarify your patient's medical history prior to a review or information received from your patient during the review, such as why and how they are supposed to use their medications.
- After a CMR, the MTM provider may contact you with questions or recommendations about your patient's medications, or your patient may call you to discuss suggestions they received from the MTM provider.

Targeted medication reviews (TMRs) are processed throughout the year, at least quarterly, to identify specific or potential medication-related problems. You may be contacted by the MTM provider if a TMR identifies a potential medication-related problem for your patient.

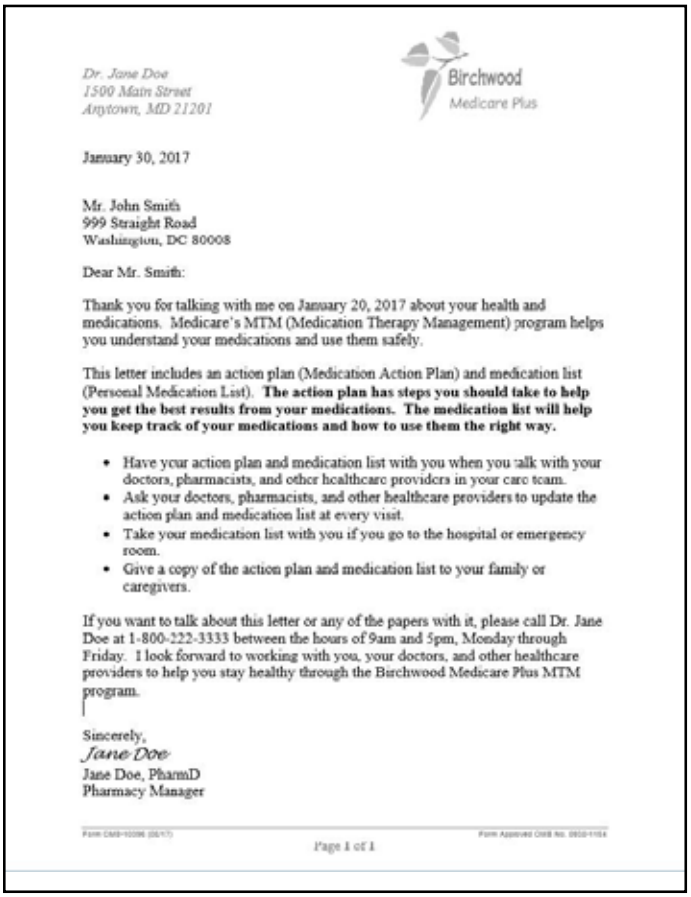
Other communications may be sent to you periodically throughout the year. These communications are intended to help resolve other potential medication-related problems or identify other opportunities to optimize your patient's medication use.

What materials will my patients receive?

If your patients are enrolled in a Part D MTM program, they will receive a printed standardized summary, Form CMS-10396, as a reference about their CMR. This summary will include a cover letter, medication action plan, and personal medication list. Your patients are encouraged to share these documents with you and other healthcare providers at their regular visits and request updates as needed. Examples of the three forms follow:

Cover letter

- The cover letter reminds your patient of their CMR, introduces the Medication action plan and personal medication list, and describes how to contact the MTM program.



Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood
Medicare Plus

January 30, 2017

Mr. John Smith
999 Straight Road
Washington, DC 80008

Dear Mr. Smith:

Thank you for talking with me on January 20, 2017 about your health and medications. Medicare's MTM (Medication Therapy Management) program helps you understand your medications and use them safely.

This letter includes an action plan (Medication Action Plan) and medication list (Personal Medication List). **The action plan has steps you should take to help you get the best results from your medications. The medication list will help you keep track of your medications and how to use them the right way.**

- Have your action plan and medication list with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team.
- Ask your doctors, pharmacists, and other healthcare providers to update the action plan and medication list at every visit.
- Take your medication list with you if you go to the hospital or emergency room.
- Give a copy of the action plan and medication list to your family or caregivers.

If you want to talk about this letter or any of the papers with it, please call Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday. I look forward to working with you, your doctors, and other healthcare providers to help you stay healthy through the Birchwood Medicare Plus MTM program.

Sincerely,
Jane Doe
Jane Doe, PharmD
Pharmacy Manager

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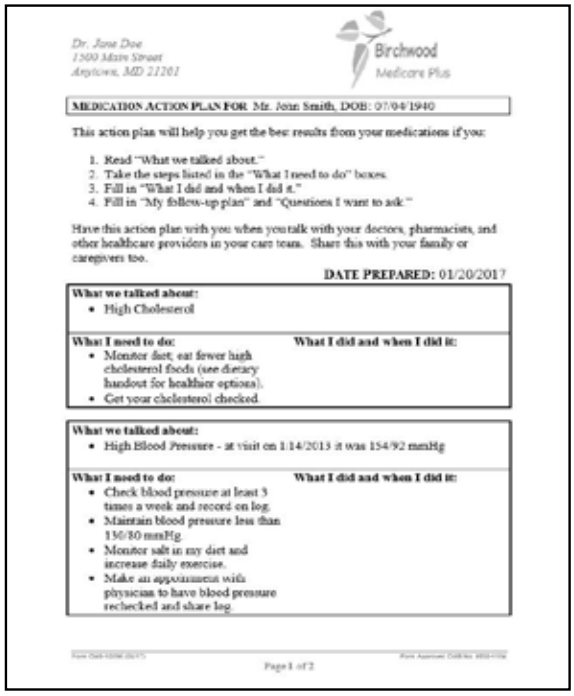
Medication action plan

- The medication action plan describes the specific action items for your patient to help resolve issues of current drug therapy and achieve the goals of medication treatment. Your patient can keep notes of their progress and use it to clarify and discuss any concerns about their medications and treatment plans with you.
- The MTM provider will send separate recommendations to you if needed.



Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood Medicare Plus

MEDICATION ACTION PLAN FOR Mr. John Smith, DOB: 07/04/1940

This action plan will help you get the best results from your medications if you:

1. Read "What we talked about."
2. Take the steps listed in the "What I need to do" boxes.
3. Fill in "What I did and when I did it."
4. Fill in "My follow-up plan" and "Questions I want to ask."

Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team. Share this with your family or caregivers too.

DATE PREPARED: 01/20/2017

What we talked about:	
• High Cholesterol	
What I need to do:	**What I did and when I did it:**
• Monitor diet; eat fewer high cholesterol foods (see dietary handout for healthier options). • Get your cholesterol checked.	

What we talked about:	
• High Blood Pressure - at visit on 1/14/2013 it was 154/92 mmHg	
What I need to do:	**What I did and when I did it:**
• Check blood pressure at least 3 times a week and record on log. • Maintain blood pressure less than 130/80 mmHg. • Monitor salt in my diet and increase daily exercise. • Make an appointment with physician to have blood pressure rechecked and share log.	

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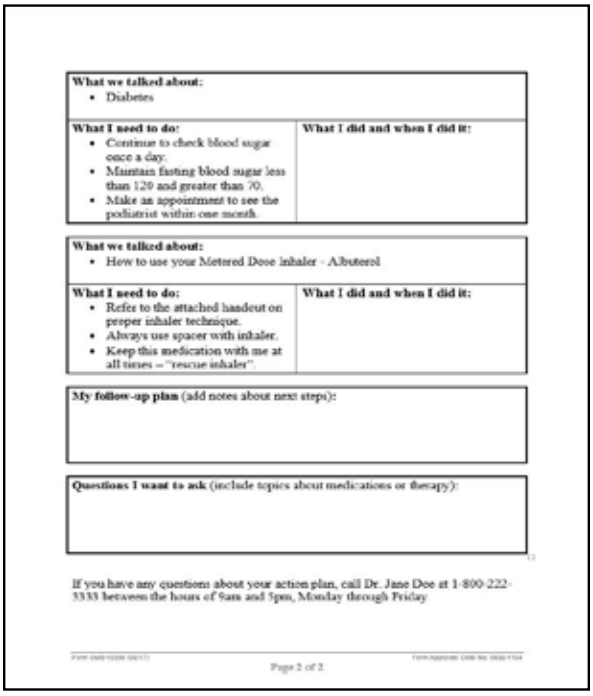

What we talked about: • Diabetes	
What I need to do: • Continue to check blood sugar once a day. • Maintain fasting blood sugar less than 120 and greater than 70. • Make an appointment to see the podiatrist within one month.	**What I did and when I did it:**

What we talked about: • How to use your Metered Dose Inhaler - Albuterol	
What I need to do: • Refer to the attached handout on proper inhaler technique. • Always use spacer with inhaler. • Keep this medication with me at all times – "rescue inhaler".	**What I did and when I did it:**

My follow-up plan (add notes about next steps):

Questions I want to ask (include topics about medications or therapy):

If you have any questions about your action plan, call Dr. Jane Doe at 1-800-222-3333 between the hours of 9am and 5pm, Monday through Friday.

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Personal medication list

- The personal medication list is a reconciled list of the medications used by your patient at the time of the review. Information from your patient, Medicare Part D claims data, or other sources may be used to develop the list. It is intended to help your patient understand their medications and how they relate to their treatment plans. Your patient can make notes on their personal medication list such as when and why they stopped taking a medication.
- You can use the personal medication list as verification of your patient's current medication regimen and provide written adjustments, as needed. The medication list can also improve communication with you and other healthcare providers seen by your patient.

Dr. Jane Doe
1500 Main Street
Anytown, MD 21201

Birchwood Medicare Plus

PERSONAL MEDICATION LIST FOR Mr. John Smith, DOB: 07/04/1940

This medication list was made for you after we talked. We also used information from Medicare Part D claims data.

- Use blank rows to add new medications. Then fill in the dates you started using them.
- Cross out medications when you no longer use them. Then write the date and why you stopped using them.
- Ask your doctors, pharmacists, and other healthcare providers in your care team to update this list at every visit.

Keep this list up-to-date with:
- ☐ prescription medications
- ☐ over the counter drugs
- ☐ herbals
- ☐ vitamins
- ☐ minerals

If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

DATE PREPARED: 01/20/2017

Allergies or **side effects:** Penicillin - hives and difficulty swallowing

Medication: Simvastatin 20 mg tablet	
How I use it: Take one tablet (20 mg) by mouth every night	
Why I use it: High Cholesterol	**Prescriber:** Dr. Joe Anne
Goals: • LDL (Low Density Lipoproteins) < 100 mg/dL • HDL (High Density Lipoproteins) > 40 mg/dL	
Date I started using it: January 2013	**Date I stopped using it:**
Why I stopped using it:	

Medication: Glipizide XL (Glucotrol XL) 5 mg tablet	
How I use it: Take one tablet (5mg) by mouth once daily	
Why I use it: Type 2 Diabetes	**Prescriber:** Dr. Joe Anne
Date I started using it: June 2014	**Date I stopped using it:**
Why I stopped using it:	

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PERSONAL MEDICATION LIST FOR Mr. John Smith, DOB: 07/04/1940
(Continued)

Medication: Acetaminophen 325 mg tablet	
How I use it: Take one tablet (325 mg) by mouth as needed for pain (3-4 tablets usually each day)	
Why I use it: Knee Pain	**Prescriber:** Self
Reminder: • Taking more than 3000mg of Acetaminophen a day can increase your chance of liver toxicity. • Do not drink alcohol with this medication. It can increase your risk of liver problems.	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication: Albuterol Sulfate Inhalation Solution (Ventolin HFA)	
How I use it: Use 2 puffs every 6 hours as needed for shortness of breath	
Why I use it: Breathing	**Prescriber:** Dr. Joe Anne
Reminder: • Refer to leaflet on proper technique. • Keep with you at all times – "rescue inhaler."	
Date I started using it: Early 2005	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
Notes:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

Medication:	
How I use it:	
Why I use it:	**Prescriber:**
Notes:	
Date I started using it:	**Date I stopped using it:**
Why I stopped using it:	

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How do you refer patients to MTM services?

Calling the prescription drug plan directly is the best way to find out if your patient is eligible for that plan's MTM services. You can also refer your patient to their local State Health Insurance Assistance Program (SHIP) office. A local SHIP counselor can be found by searching the following website: *https://www.shiptacenter.org*.

Part D enhanced medication therapy management model

Certain plans in Arizona, Florida, Iowa, Louisiana, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Virginia, and Wyoming are participating in a new test to determine if expanded MTM services can help improve health outcomes and reduce health care expenditures. Participating plans are permitted to target enrollees using a different criteria than the standard MTM program and offer additional services beyond the CMR and TMR to improve their medication usage. If one of your patients is enrolled in a participating plan, the Part D plan may reach out to you to better coordinate care and improve information sharing.

Summary

Medicare Part D MTM programs promote coordinated care and improve medication use through services that engage the patient, their physicians, and other healthcare providers. You may see three forms that your patients will receive if they are enrolled in a Part D MTM program and have received a CMR. These forms are intended to provide the patient with information about their medication use and also be used as a platform for discussion with you and their other health care providers.

Additional information

For additional information about Medicare Part D MTM programs and the standardized CMR summary documents, go to *https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html*.

Please send any general questions about Part D MTM

programs to *PartD_MTM@cms.hhs.gov*. Questions about a specific plan's MTM services or eligibility criteria should be addressed to that Part D plan.

Document history

Date of change	Description
August 24, 2017	The article was revised to provide updated information primarily in the new "Part D enhanced medication therapy management model" section.
October 11, 2012	Initial article issued

MLN Matters® Number: SE1229 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider-based determination checklists

***Note**: This article was revised September 7, 2017, to remove a reference to checklists that should not have been included. All other information remains the same. This information was previously published in the August 2017 Medicare A Connection, page 4.*

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. 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.

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
September 7, 2017	The article was revised September 7, 2017, to remove a reference to checklists that should not have been included.
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

Quarterly provider update

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

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

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

Medicare Overpayment Manual update – limitation on recoupment

Provider type affected

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

Provider action needed

Change request (CR) 9815 updates the Centers for Medicare & Medicaid Services (CMS) *Medicare Financial Management Manual*, Chapter 3, Sections 200-200.2.1, *Limitation on Recoupment Overpayments*. CR 9815 is the first of four CRs that are forthcoming and incorporated into this manual. Make sure your billing staffs are aware of these updates that relate to the limitation on recovery of certain overpayments.

Background

Section 1893(f)(2)(a) of the Social Security Act and the provision in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) prohibits recouping Medicare overpayments from a provider or supplier that seeks a reconsideration from a qualified independent contractor (QIC). This provision changed how interest is to be paid to a provider or supplier whose overpayment is reversed at subsequent administrative or judicial levels of appeal. The final rule defines the overpayments to which the limitation applies, how the limitation works in concert with the appeals process, and the change in our obligation to pay interest to a provider or supplier whose appeal is successful at levels above the QIC. This section also limits recoupment of Medicare overpayments when a provider or supplier seeks a redetermination until a redetermination decision is rendered.

The MAC will cease recoupment or not begin recoupment when the MAC receives a valid redetermination or reconsideration request timely on an overpayment subject to these limitations The provider has until the appeal deadline to file an appeal (refer to the *Medicare Claims Processing Manual*, Chapter 29 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf*). If a provider wants to delay recoupment, it must submit the redetermination appeal request within 30 days of the demand letter date. To continue the delayed recoupment, the provider will have 60 days from the redetermination decision to submit a reconsideration request. If the request is received before the appeal deadline but after recoupment has started, the MAC will stop the recoupment. The MAC shall not refund any monies collected back to the provider, unless otherwise directed by the Centers for Medicare & Medicaid Services (CMS). The MAC will be accountable to ensure the debts continue to age and accrue interest until the debt is paid in full.

After the first two levels of appeal are completed, the MAC shall resume recoupment and normal debt collection processes. Whether or not the provider subsequently appeals the overpayment to the administrative law judge (ALJ), or subsequent levels (department appeals board (DAB), or federal court), the MAC shall initiate recoupment at 100 percent until the debt is satisfied in full, unless an extended repayment schedule (ERS) is established. If the debt was referred to treasury and the provider files for an appeal, the MAC shall recall the debt from treasury while in an appeal status. If the appeal decision is unfavorable to the provider, any outstanding debt will be referred back to treasury, unless an approved ERS is established or the provider pays the debt in full.

Additional information

The official instruction, CR 9815, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R293FM.pdf*.

Chapter 29 of the *Medicare Claims Processing Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.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
September 15, 2017	The article was revised to reflect an updated CR that corrected format errors in the manual instructions. In the article, the CR release date, transmittal number, and link to the transmittal changed.
September 1, 2017	Initial article issued

MLN Matters® Number: MM9815
Related Change Request (CR) #: CR 9815
Related CR Release Date: September 14, 2017
Effective Date: April 2, 2018
Related CR Transmittal #: R293FM
Implementation Date: April 2, 2018

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 *https://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

More information

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

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

Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

New 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.

Revised LCDs

Psychiatric partial hospitalization program – revision to the Part A LCD

LCD ID number: L33972 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for psychiatric partial hospitalization program was revised to remove *Current Procedural Terminology* (CPT®) codes 90875 and 90876 from the "CPT/HCPCS Codes" section of the LCD as they are nationally noncovered by Medicare.

Effective date

This LCD revision is effective for claims processed on or after August 31, 2017.

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

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

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

Vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases – revision to the Part A and Part B LCD

LCD ID number: L36962 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an external correspondence related to the new Food and Drug Administration (FDA) approved indication, diabetic retinopathy in patients without diabetic macular edema, for Lucentis® (ranibizumab injection), the local coverage determination (LCD) for vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases was revised. The following ICD-10-CM diagnosis codes were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) code J2778: E08.319, E08.3291-E08.3293, E08.3391-E08.3393, E08.3491-E08.3493, E08.3521-E08.3523, E08.3531-E08.3533, E08.3541-E08.3543, E08.3551-E08.3553, E08.3591-E08.3593, E09.319, E09.3291-E09.3293, E09.3391-E09.3393, E09.3491-E09.3493, E09.3521-E09.3523, E09.3531-E09.3533, E09.3541-E09.3543, E09.3551-E09.3553, E09.3591-E09.3593, E10.3521-E10.3523 E10.3531-E10.3533, E10.3541-E10.3543, E10.3551-E10.3553, E11.3521-E11.3523, E11.3531-E11.3533, E11.3541-E11.3543, E11.3551-E11.3553, E13.3521-E13.3523, E13.3531-E13.3533, E13.3541-E13.3543, and E13.3551-E13.3553.

Effective date

This LCD revision is effective for claims processed **on or after October 2, 2017**, for services rendered **on or after July 24, 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*.

Additional Information

2018 ICD-10-CM Coding Changes (Part A/B, Part A, and Part B)

The 2018 update to the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) diagnosis coding structure is effective for services rendered on or after October 1, 2017. First Coast Service Options Inc. (First Coast) medical policy team has evaluated all active local coverage determinations (LCDs) for diagnosis /procedure coding system (PCS) codes criteria that are impacted by the 2018 ICD-10-CM update. As a reminder, diagnosis codes included in an LCD are surrogate to the indications addressed within the LCD and providers are required to bill to the highest level of specificity for the applicable diagnosis code when reporting services. ICD-10-CM diagnosis codes /PCS codes have been added, revised, and deleted. The following is a list of the impacted LCDs.

Part A/B Combined LCDs

L36767 - Aortography and peripheral angiography

L33609 - Autonomic Function Tests

L33268 - Bendamustine hydrochloride (Treanda®, Bendeka™)

L33273 - Bortezomib (Velcade®)

L33267 - B-Type Natriuretic Peptide (BNP)

L36209 - Cardiology – non-emergent outpatient testing exercise stress test, stress echo, MPI SPECT, and cardiac PET

L33282 - Computed Tomographic Angiography of the Chest, Heart, and Coronary Arteries

L33283 - Computed Tomographic Colonography

L35698 - CYP2C19, CYP2D6, CYP2C9 and VKORC1 Genetic Testing

L33583 - Diagnostic and Therapeutic Esophagogastroduodenoscopy

L33671 - Diagnostic Colonoscopy

L33990 - Doxorubicin HCl

L33669 - Electrocardiography

L36276 - Erythropoiesis Stimulating Agents

L33997 - Fluorescein Angiography

L33670 - Fundus Photography

L36773 - Intensity Modulated Radiation Therapy (IMRT)

L34006 - Interspinous Process Decompression

L34007 - Intravenous Immune Globulin

L34012 - Leucovorin (Wellcovorin®)

L33380 - Long-Term Wearable Electrocardiographic Monitoring (WEM)

L33382 - Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions

L34014 - Magnesium

L33618 - Major Joint Replacement (Hip and Knee)

L34859 - Nerve Conduction Studies and Electromyography

L33693 - Non-Invasive Evaluation of Extremity Veins

L34017 - Ophthalmoscopy

L33747 - Pegfilgrastim (Neulasta®)

L33252 - Psychiatric Diagnostic Evaluation and Psychotherapy Services

L34520 - Psychological and Neuropsychological Tests

L33707 - Pulmonary Diagnostic Services

L33751 - Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

L36342 - Screening and Diagnostic Mammography

L34023 - Strapping

L33411 - Surgical Management of Morbid Obesity

L33413 - Therapy and Rehabilitation Services

L34031 - Total Calcium

L33762 - Treatment of varicose veins of the lower extremity

L36962 - Vascular Endothelial Growth Factor Inhibitors for the Treatment of Ophthalmological Diseases

L33766 - Visual Field Examination

L33771 - Vitamin D; 25 hydroxy, includes fraction(s), if performed

Part A only LCD

L33970 - Frequency of Hemodialysis Services

L33974 - Troponin

See **ICD-10**, next page

Self-administered drug (SAD) list – revision to the Part A and Part B article

Article ID number: A52571 (Florida, Puerto Rico/U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered **on or after November 16, 2017**, the following drugs have been added to the MAC Jurisdiction N (JN) self-administered drug (SAD) list:

- Corticotropin, up to 40 units (H.P. Acthar® Gel, subcutaneous) - J0800
- Apomorphine hydrochloride, 1 mg (Apokyn) – J0364
- Amjevita™ (adalimumab-atto) – C9399/J3490/J3590
- Dupixent® (dupilumab) – C9399/J3490/J3590
- Erelzi™ (etanercept-SZZS) – C9399/J3490/J3590
- Kynamro®, (Mipomersen sodium) – C9399/J3490/J3590
- Orencia®, subcutaneous only – C9399/J3490/J3590
- Quad-Mix – C9399/J3490/J3590
- Rasuvo® (methotrexate, injection for subcutaneous use) – C9399/J3490/J3590
- Siliq™ (brodalumab) – C9399/J3490/J3590

In addition, the following brand name drugs have been added to the MAC Jurisdiction N (JN) SAD list:

- J1595: Glatopa®
- J1830: Extavia®;
- J2941: Norditropin® and Zomacton™;
- J3030: Sumavel®, Dosepro®, and Zembrace™;
- C9399, J3490, J3590: Pegasys® Proclick™.

The evaluation of drugs for addition to the SAD list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options Inc. (First Coast) SAD lists are available at: /Self-administered_drugs/

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Part B only LCDS

L33903 - Diagnostic Laryngoscopy
L33906 - Epidural
L33923 - Noninvasive Ear or Pulse Oximetry For Oxygen Saturation
L33933 - Peripheral Nerve Blocks
L33957 - Sacroiliac Joint Injection
L33958 - Somatosensory Testing
L33977 - Transcranial Doppler Studies

Effective date

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

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

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

OIG reports highlight hospital billing issues

Provider type affected

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

Provider action needed

In two recent reports, the Office of Inspector General (OIG) cites two significant issues in which hospitals are making coding errors on Medicare claims. Correct coding of claims is important for hospitals to avoid improper payments, which can lead to recoveries of overpayments. The Centers for Medicare & Medicaid Services (CMS) encourages hospital billing and coding personnel to review the OIG reports and take steps to avoid the problems identified in those reports. It is also very important that claims submitted are supported by documentation in the beneficiary's medical records.

Background

The OIG reports referenced in this article focused on claims for right heart catheterizations (RHCs) with heart biopsies that used modifier 59 and claims for 96 or more continuous hours of mechanical ventilation.

Improper use of modifier 59

In the first report, *Hospitals Nationwide Generally Did Not Comply with Medicare Requirements for Billing Outpatient Right Heart Catheterizations with Heart Biopsies*, the OIG analyzed claims to determine if hospitals were correctly reporting modifier 59 for RHCs and heart biopsies. The OIG found that in billing for outpatient RHCs with heart biopsies, hospitals often use modifier 59 inappropriately, which leads to significant overpayments and overpayment recoveries on claims for these services.

Providers may want to review *MLN Matters® special edition article SE1418* on the *Proper use of modifier 59*. Providers may also want to review *MLN Matters® article MM8863* (based on change request (CR) 8863.

Medicare billing policy allows hospitals to include modifier 59, which indicates that a procedure is separate and distinct from another procedure performed on the same patient on the same day when the procedures performed were separate and distinct. Some hospitals incorrectly billed outpatient RHCs that were performed during the same patient encounter as heart biopsies. By appending modifier -59 to the HCPCS code to claims for RHCs and heart biopsies, some hospitals represented that the RHCs were separate and distinct from the heart biopsies; however, the payment for a heart biopsy is generally intended to cover an RHC when the RHC is performed during the same encounter.

For example, a hospital billed a procedure with modifier 59 for a beneficiary who received an RHC and a heart biopsy on the same date of service. The medical record documentation did not support the use of the modifier and, as a result, Medicare made an overpayment on the claim. Medicare recovered the overpayment.

Incorrect procedure coding for mechanical ventilation

In the second report, *Medicare Improperly Paid Hospitals for Beneficiaries Who Had Not Received 96 or More Consecutive Hours of Mechanical Ventilation*, the OIG states that hospitals often use incorrect procedure codes when billing for mechanical ventilation. In their study of mechanical ventilation billings, the OIG looked at the relation between Medicare severity - diagnosis related groups (MS-DRGs) billed to the procedures coded for those DRGs.

Specifically, the OIG looked at the MS-DRG 207 (Respiratory system diagnosis [with] ventilator support 96+ hours) and MS-DRG 870 (Septicemia or severe sepsis [with mechanical ventilation] 96+ hours). The OIG focused on claims where the estimated potential mechanical ventilation procedure length was four days or less, based on the date the hospital reported on the claim that mechanical ventilation started. Some hospitals billed MS-DRGs that indicated a stay where 96 or more consecutive hours of mechanical ventilation was provided to the beneficiary, while the estimated potential mechanical ventilation procedure length indicated four days or less. Such claims represent overpayments.

In some instances, it appears that coders were likely looking at the number of days in a stay when coding the procedure code for ventilator support. For example, medical record documentation (physician's notes and ventilation records) showed a beneficiary received 68 hours of mechanical ventilation with a stay of four days or fewer. However, the claim procedure code showed 96 or more hours of mechanical ventilation were provided. This caused the claim to be grouped to MS-DRG 870 rather than MS-DRG 871. This resulted in a significant overpayment that Medicare recovered from the hospital.

In another example, medical record documentation (ventilation records) showed that a beneficiary was in the hospital for five days and received a total of 91 hours of ventilation, but the procedure code on the claim indicated 96 or more consecutive hours of mechanical ventilation was provided. This also resulted in grouping the claim to a MS-DRG that led to a higher and incorrect payment, which Medicare recovered from the hospital.

Additional information

Medicare encourages hospital billing and coding staff to review the Medicare manual sections and other sources noted in the resources below to ensure proper billing of ventilation support services and on the proper use of modifier 59. The *Medicare Claims Processing Manual*, Chapter 3, Inpatient Hospital Billing, Section 10, *General Inpatient Requirements* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf* is a good starting point.

Providers and billing and coding staff may also want to review *MLN Matters*® special edition article SE1418 on the *Proper use of modifier 59*, which is available at *https://*

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www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1418.pdf.

Billing and coding staff may also want to review issues in the *Medicare Quarterly Provider Compliance Newsletters*, which are available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf*. Two specific issues relevant to these hospital coding problems are Volume 2, Issue 1 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp_Newsletter_ICN907163.pdf* and Volume 7, Issue 4 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN907797.pdf*.

The OIG report, *Hospitals Nationwide Generally Did Not Comply with Medicare Requirements for Billing Outpatient Right Heart Catheterizations with Heart Biopsies*, is available at *https://oig.hhs.gov/oas/reports/region1/11300511.pdf*.

The OIG report, *Medicare Improperly Paid Hospitals for Beneficiaries Who Had Not Received 96 or more Consecutive Hours of Mechanical Ventilation*, is available at *https://oig.hhs.gov/oas/reports/region9/91402041.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
September 7, 2017	Initial article released.

MLN Matters® Number: SE17017
Initial Article Release Date: September 7, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Enforcement of the partial hospitalization program 20 hours per week billing requirement

***Note**: This article was rescinded August 18, 2017. This information was previously published in the July 2016 Medicare A Connection, pages 25-26.*

Additional information

If you have any questions, please contact your MAC at their toll-free number, which may be found at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

Chapter 6 of the *Medicare Benefit Policy Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf*.

Document history

Date of change	Description
August 18 2017	**Article is rescinded.**
July 19, 2017	This article was revised July 19 to add a reference to *MLN Matters*® article MM9880. *MM9880* states that CR 9880 implements informational messaging, effective October 1 that conveys supplemental and educational information to the provider submitting claims for PHP services where the patient did not receive the minimum 20 hours per week of therapeutic services his plan of care indicates is required, on claims with line item date of service (LIDOS) on or after October 1.
July 7, 2016	Article revised to announce suspension of three new edits that were to be effective on July 1, 2016.
March 31, 2016	Initial issuance.

MLN Matters® Number: SE1607 *Rescinded*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: July 1, 2016
Related CR Transmittal #: N/A
Implementation Date: July 5, 2016

2018 annual update of HCPCS codes for skilled nursing facility consolidated billing

Provider type affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs and durable medical equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

Change request (CR) 10262 makes changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare physician fee schedule designations that will be used to revise common working file (CWF) edits to allow A/B MACs to make appropriate payments in accordance with policy for SNF CB in Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6 in the *Medicare Claims Processing Manual*.

Background

The common working file (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid. Barring any delay in the Medicare physician fee schedule, the new code files will be provided to CWF by November 1, 2017.

By the first week in December 2017, new code files will be posted at *https://www.cms.gov/SNFConsolidatedBilling/*. The files will be applicable to claims with dates of service on or after January 1, 2018, through December 31, 2018. It is **important and necessary** for the provider/contractor community to view the "General Explanation of the Major Categories" file located at the bottom of each year's update in order to understand the major categories including additional exclusions not driven by HCPCS codes.

Additional information

The official instruction, CR 10262, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3857CP.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
September 8, 2017	Initial article released.

MLN Matters® Number: MM10262
Related CR Release Date: September 8, 2017
Related CR Transmittal Number: R3857CP
Related Change Request (CR) Number: 10262
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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.

Claim status category and claim status codes update

Provider type affected

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

Provider action needed

Change request (CR) 10132 updates, as needed, the claim status and claim status category codes used for the Accredited Standards Committee (ASC) X12 276/277, Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these updates.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting, held each year in January or February, June, and in September or October. At these meetings, the Committee makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry six months for implementation of newly added or changed codes.

The code sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claimstatus-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-statuscodes/* . Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the September/October 2017 Committee meeting shall be posted on the above websites on or about November 1, 2017.

The Centers for Medicare & Medicaid Services (CMS) will issue instructions to the MACs who then must update their claims systems to ensure that the current version of these codes is used in their claim status responses.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 10132. References in CR 10132 to "277 responses," and "claim status responses," encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

Additional information

The official instruction, CR 10132, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3839CP.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 18, 2017	Initial article released.

MLN Matters® Number: MM10132
Related CR Release Date: August 18, 2017
Related CR Transmittal Number: R3839CP
Related Change Request (CR) Number: 10132
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Tools to improve your billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

Healthcare provider taxonomy codes October 2017 update

Provider types affected

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

Provider action needed

Change request (CR) 10141 instructs MACs to obtain the most recent healthcare provider taxonomy code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

You should note that:

- Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) for current use.
- Terminated codes are not approved for use after a specific date.
- Newly approved codes are not approved for use prior to the effective date of the codeset update in which each new code first appears.
- Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.
- Medicare would be guilty of non-compliance with HIPAA if MACs accepted claims that contain invalid HPTCs.

The HPTC set is maintained by the NUCC for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view from the Washington Publishing Company (WPC) website at *www.wpc-edi.com/codes* and can be downloaded from the NUCC's website *http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40*.

Although the NUCC generally posts their updates on the WPC webpage three months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the health care provider taxonomy code set online, you can identify revisions made since the last release by color code:

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

Additional information

The official instruction, CR 10141, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2017Downloads/R3842CP.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 18, 2017	Initial article released

MLN Matters® Number: MM10141
Related CR Release Date: August 18, 2017
Related CR Transmittal Number: R3842CP
Effective Date: October 1, 2017
Implementation Date: January 2, 2018; contractors with capability to do so will implement effective October 1, 2017

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp.* This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

CORE 360 uniform use of CARC, RARC and CAGC rule

Provider types affected

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

Provider action needed

Change request (CR) 10140 instructs MACs and Medicare's shared system maintainers (SSMs) to update systems based on the CORE 360 uniform use of claim adjustment reason codes (CARC), remittance advice remark codes (RARC), and claim adjustment group code (CAGC) Rule publication. These system updates are based on the CORE code combination list to be published on or about October 1, 2017.

Background

The Department of Health and Human Services (DHHS) adopted the Phase III CAQH CORE, EFT and ERA operating rule set that was implemented on January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE will publish the next version of the code combination list on or about October 1, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about July 1, 2017. This will also include updates based on market-based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare as the industry needs them. See *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

Note: The Affordable Care Act mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE-defined business scenarios. With the four CORE-defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 10140, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3841CP.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 18, 2017	Initial article released

MLN Matters® Number: MM10140
Related Change Request (CR) Number: CR10140
Related CR Release Date: August 18, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3841CP
Implementation Date: January 2, 2018

Take action to combat the flu

Now is the perfect time for providers to vaccinate Medicare beneficiaries, as it can take two weeks after vaccination to develop antibodies that protect against seasonal influenza. As a health care provider, you play an important role in setting an example by getting yourself vaccinated and recommending and promoting influenza vaccination.

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

***Note**: This article was revised September 13, 2017, to reflect a revised change request (CR). That CR removed a business requirement to the Medicare administrative contractors (MACs). The CR release date, transmittal number, and link to the transmittal also changed. All other information is unchanged. This information was previously published in the August 2017 Medicare A Connection, pages 20-21.*

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.

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/R1918OTN.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
September 13, 2017	The article was revised to reflect a revised CR. That CR removed a business requirement to the MACs. The CR release date, transmittal number, and link to the transmittal also changed.
July 28, 2017	Initial article released

MLN Matters® Number: MM10145
Related CR Release Date: September 13, 2017
Related CR Transmittal Number: R1918OTN
Related Change Request (CR) Number: 10145
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

FY 2018 IPPS and LTCH PPS changes

Provider type 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

Change request (CR) 10273 implements policy changes for the fiscal year (FY) 2018 inpatient prospective payment system (IPPS) and LTCH prospective payment system (PPS). Failure to adhere to these new policies could affect payment of Medicare claims.

Background

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a 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.

IPPS FY 2018 update

The following policy changes for FY 2018 were displayed in the *Federal Register* August 2, 2017, with a publication date of August 14, 2017. All items covered in CR10273 are effective for hospital discharges occurring on or after October 1, 2017, through September 30, 2018, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2017, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2017, through September 30, 2018.

Files for download listed throughout the CR are available on the Centers for Medicare & Medicaid Services (CMS) website. The key links are:

- FY 2018 Final Rule Tables webpage: *https://www.cms.gov/Medicare/Medicare-Fee-forService-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-PageItems/FY2018-IPPS-Final-Rule-Tables.html*
- FY 2018 Final Rule Data Files webpage: *https://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-PageItems/FY2018-IPPS-Final-Rule-Data-Files.html*

IPPS FY 2018 update

A. FY 2018 IPPS rates and factors

For the operating rates/standardized amounts and the federal capital rate, refer to Tables 1A-C and Table 1D, respectively, of the FY 2018 IPPS/LTCH PPS final rule, available on the FY 2018 Final Rule Tables webpage. For other IPPS factors, including applicable percentage increase, budget neutrality factors, high cost outlier (HCO) threshold, and cost-of-living adjustment (COLA) factors, refer to the MAC implementation files 1 available on the FY 2018 MAC Implementation Files webpage.

B. Medicare severity-diagnosis release group (MS-DRG) grouper and Medicare code editor (MCE) changes

The grouper contractor, 3M Health Information Systems (3M-HIS), developed the new International Statistical Classification of Diseases and Related Health Problems 10th Revision

(ICD-10) MS-DRG Grouper, Version 35.0, software package effective for discharges on or after October 1, 2017. The GROUPER assigns each case into a MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The ICD-10 MCE Version 35.0 which is also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2017.

For discharges occurring on or after October 1, 2017, the fiscal intermediary shared system (FISS) calls the appropriate GROUPER based on discharge date. For discharges occurring on or after October 1, 2017, the MCE selects the proper internal code edit tables based on discharge date.

For the October update, CMS has:

- Reduced the number of MS-DRGs from 757 to 754 for FY 2018. CMS is not implementing any new MS-DRGs for FY 2018. In addition, CMS is deleting MS-DRGs 984, 985 and 986.
- Revised the title to MS-DRG 023 to Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator.
- Modified the titles for MS-DRGs 061, 062, and 063 to Ischemic Stroke, Precerebral Occlusion or Transient Ischemia with Thrombolytic Agent w MCC, CC and without CC/MCC, respectively, and retitled MS-DRG 069 to Transient Ischemia without Thrombolytic.
- Revised the titles for MS-DRGs 246 and 248 to state “arteries” instead of “vessels” to better reflect the I-10 terminology in the classification. The revised titles for MS-DRGs 246 and 248 are Percutaneous cardiovascular procedures

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with drug-eluting stent with MCC or 4+ arteries or stents and Percutaneous cardiovascular procedures with nondrug-eluting stent with MCC or 4+ arteries or stents, respectively.

- Modified the title for MS-DRGs 469 and 470 to Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement and Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC, respectively.

- Revised the titles for MS-DRGs 823, 824 and 825 to Lymphoma and Non-Acute Leukemia with Other Procedure with MCC, with CC and without CC/MCC, respectively.

- Revised the titles for MS-DRGs 829 and 830 to Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedure with CC/MCC and without CC/MCC, respectively.

C. Post-acute transfer and special payment policy

The changes to MS-DRGs for FY 2018 have been evaluated against the general post-acute care transfer policy criteria using the FY 2016 MedPAR data according to the regulations under Sec. 412.4 (c). As a result of this review, no new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy; however MS-DRGs 987, 988 and 989 (Non-Extensive O.R. Procedure Unrelated To Principal Diagnosis with major complication or comorbidity (MCC), with complication or comorbidity (CC), without CC/MCC, respectively) were added to the special payment policy list. See Table 5 of the FY 2018 IPPS/LTCH PPS final rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2018 Final Rule Tables webpage.

D. New technology add-on

The following items will *continue* to be eligible for new-technology add-on payments in FY 2018:

1. 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 or XW04392
2. 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
3. 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
4. Name of approved new technology: Vistogard™
   - Maximum add-on payment: $40,130 (Note: The maximum payment has changed from FY 2018)
   - Identify and make new technology add-on payments with any of the following ICD-10 clinical modification (ICD-10-CM) diagnosis codes T45.1x1A, T45.1x1D, T45.1x1S, T45.1x5A, T45.1x5D, or T45.1x5S in combination with (ICD-10-PCS procedure code XW0DX82

The following items are eligible for new-technology add-on payments in FY 2018:

5. Name of approved new technology: ZINPLAVA™
   - Maximum add-on payment: $1,900
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes XW033A3 or XW043A3.
6. Name of approved new technology: Stelara®
   - Maximum add-on payment: $2,400
   - Identify and make new technology add-on payments with ICD-10-PCS procedure code XW033F3.
7. Name of approved new technology: EDWARDS INTUITY Elite™ Valve System (INTUITY) and LivaNova Perceval Valve (Perceval)
   - Maximum add-on payment: $6,110.23
   - Identify and make new technology add-on payments with ICD-10-PCS code X2RF032.

E. Cost of living adjustment (COLA) update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. CMS has updated the COLAs for FY 2018, and the COLAs for the qualifying counties in all of Alaska and in Hawaii is 1.25, except for the county of Hawaii which is 1.21. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2017, are available in

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the FY 2018 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2018 MAC Implementation Files webpage.

F. FY 2017 wage index changes and issues

1. Transitional wage indexes

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.

For hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, 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 for FY 2015, 2016, and 2017. These hold harmless wage indexes have expired for FY 2018. MACs will ensure hospitals that were eligible for transitional wage indexes in FY 2017 no longer receive a transitional wage index for FY 2018.

2. Adoption of federal information processing standard (FIPS) county codes

Core-based statistical areas (CBSAs) are made up of one or more constituent counties. Each CBSA and constituent county has its own unique identifying codes. There are two different lists of codes associated with counties: Social Security Administration (SSA) codes and FIPS codes. Historically, CMS has listed and used SSA and FIPS county codes to identify and crosswalk counties to CBSA codes for purposes of the hospital wage index. CMS has learned that SSA county codes are no longer being maintained and updated. However, the FIPS codes continue to be maintained by the U.S. Census Bureau. The Census Bureau's most current statistical area information is derived from ongoing census data received since 2010; the most recent data are from 2015. For the purposes of cross-walking counties to CBSAs, in the FY 2018 IPPS/LTCH PPS final rule, CMS finalized that it would discontinue the use of SSA county codes and begin using only the FIPS county codes beginning in FY 2018.

Based on information included in the Census Bureau's website, since 2010, the Census Bureau has made the following updates to the FIPS codes for counties or county equivalent entities:

- Petersburg Borough, AK (FIPS state county code 02-195), CBSA 02, was created from part of former Petersburg census area (02-195) and part of Hoonah-Angoon census area (02-105).The CBSA code remains 02.
- The name of La Salle Parish, LA (FIPS state county code 22-059), CBSA 14, is now LaSalle Parish, LA (FIPS state county code 22-059).The CBSA code remains as 14.
- The name of Shannon County, SD (FIPS state county code 46-113), CBSA 43, is now Oglala Lakota County, SD (FIPS state county code 46-102).The CBSA code remains as 43.

CMS adopted the implementation of these FIPS code updates, effective October 1, 2017, beginning with the FY 2018 wage indexes. A County to CBSA Crosswalk File is available on the FY 2018 Final Rule Data Files webpage.

Note: The county update changes listed above changed the county names. However, the CBSAs to which these counties map did not change from the prior counties. Therefore, there is no payment impact or change to hospitals in these counties; they continue to be considered rural for the hospital wage index under these changes.

3. Treatment of certain providers redesignated under Section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the 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. The following is a list of hospitals that have waived LUGAR status for FY 2018: 010164, 070004, 070011, 140167, 250117, 390008, 390031, 390150 and 520102.

4. Section 505 hospital (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 Section 1886(d)(8)(B) of the Act.

G. 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 disproportionate share hospital (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 to keep its Lugar status if it was approved for an urban to rural reclassification under § 412.103. Effective April 21, 2016, hospitals nationwide that have an MGCRB reclassification or Lugar status during FY 2016 and subsequent years can simultaneously seek urban to rural reclassification under § 412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or Lugar status.

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H. 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. Therefore, if a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CMS certification number (CCN) of the hospital in the provider-specific file (PSF), to identify and denote a sub-campus in a different CBSA, so that the appropriate wage index associated with each campus's geographic location can be assigned and used for payment for Medicare discharges from each respective campus. Also note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index needs to be noted in the PSF.

I. Updating the PSF for wage index, reclassifications and redesignations

MACs will update the PSF by following the steps, in order, in Attachment 1 of CR 10273 to determine the appropriate wage index based on policies mentioned above.

J. Expiration of Medicare-Dependent, Small Rural Hospital (MDH) Program

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. Under current law, beginning in October 1, 2017, all previously qualifying hospitals will no longer have MDH status and will be paid based solely on the federal rate. (Note that, the SCH policy at § 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.) Provider Types 14 and 15 will no longer be valid beginning October 1, 2017.

K. Hospital-specific (HSP) rate factors for sole community hospitals (SCHs)

For FY 2018, the HSP amount in the PSF for SCHs (and MDHs as applicable) 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 and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

Note: The FY 2017 2 midnight rule one time prospective increase of 1.006 (as well as the removal of 0.998 2 midnight rule adjustment applied in 2014) are not applied to the HSP update for FY 2018.

L. L. Low-volume hospitals – criteria and payment adjustments for FY 2018

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, which expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition, is currently effective through September 30, 2017, as provided by section 204 of the Medicare Access and CHIP Reauthorization Act of 2015. Under current law, beginning in October 1, 2017, the low-volume hospital qualifying criteria and payment adjustment methodology will revert to that which was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation (that is, the low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010). The regulations implementing the hospital payment adjustment policy are at § 412.101.

In addition, CMS is implementing an adjustment parallel to the low-volume hospital payment adjustment so that, for discharges occurring in FY 2018 and subsequent years, only the distance between Indian Health Service (IHS) or Tribal hospitals will be considered when assessing whether an IHS or Tribal hospital meets the mileage criterion under § 412.101(b)(2). Similarly, only the distance between non-IHS hospitals would be considered when assessing whether a non-IHS hospital meets the mileage criterion under § 412.101(b)(2). This parallel adjustment is implemented in 42 CFR 412.101(e).

For FY 2018, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2017, in order for the 25-percent, low-volume, add-on payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2017 (through September 30, 2018). Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2017 may continue to receive a low-volume hospital payment adjustment for FY 2018 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2018. As in previous years, such a hospital must send written verification that is received by its MAC no later than September 1, 2017, stating that it meets the mileage criterion applicable for FY 2018. For FY 2018, this written verification must also state, based upon the most recently submitted cost report, that the hospital meets the discharge criterion applicable for FY 2018 (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges). If a hospital's request for low-volume hospital status for FY 2018 is received after September 1, 2017, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the 25-percent, low-volume hospital payment adjustment to determine the payment for the hospital's FY 2018 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination. CMS notes that this process mirrors its established application process but is updated to ensure that providers currently receiving the low-volume hospital payment adjustment verify that they meet both the mileage criterion and the discharge criterion applicable for FY 2018 to continue receiving the adjustment for FY 2018.

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The low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH (including the uncompensated care payment), indirect medical education (IME) and outliers. For SCHs (and MDHs, when applicable), the low-volume hospital payment is based on and in addition to either payment based on the federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

M. Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at *www.qualitynet.org*. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the list.

N. Hospital Acquired Condition Reduction Program (HAC)

Under the HAC reduction program, a one-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 2018 was not publicly available in the final rule because the review and correction process was not yet completed. MACs will receive a preliminary list of hospitals subject to the HAC reduction program. Updated hospital level data for the HAC reduction program will be made publicly available following the review and corrections process.

O. Hospital value-based purchasing (VBP)

For FY 2018, 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 2018. CMS expects to post the value-based incentive payment adjustment factors for FY 2018 in the near future in Table 16B of the FY 2018 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2018 IPPS Final Rule Tables webpage).

P. Hospital Readmissions Reduction Program

The readmissions payment adjustment factors for FY 2018 are in Table 15 of the FY 2018 IPPS/LTCH PPS final rule (which are available through the Internet on the FY 2018 IPPS Final Rule Tables webpage). Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2018 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2018, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

Note: Hospitals located in Maryland (for FY 2018) and in Puerto Rico are not subject to the Hospital Readmissions Reduction Program, and therefore, are not listed in Table 15. Therefore, MACs shall follow the instructions in the second bullet above for the PSF for these hospitals.

Q. Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Under current law, 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 for FY 2018 is based on the average of three individual Factor 3s calculated based on cost reporting periods beginning in FY 2012, FY 2013, and FY 2014. The individual Factor 3s for FY 2012 and FY 2013 are based on Medicaid days and Medicare SSI days, while the Factor 3 for FY 2014 is based on hospital uncompensated care costs. For FY 2018, the denominators used in the calculation of Factor 3 for FY 2012, FY 2013, and FY 2014 cost reporting years are 36,967,682 days, 37,321,428 days, and $25,186,285,084, respectively.

The Medicare DSH payment is 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 is applied in PRICER.

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2018 IPPS final rule, and the uncompensated care payment will continue to be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2018. 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 SCHs to determine if a claim is paid under the hospital-specific rate or federal rate (and for MDHs 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, when applicable). 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.

The Uncompensated Care Per Discharge Amount and Projected DSH Eligibility are located in the Medicare DSH Supplemental Data File for FY 2018, which are available through the Internet on the FY 2018 Final Rule Data Files webpage. Column A of the Medicare DSH Supplemental Data File is the provider CCN; Column I is the uncompensated care per discharge amount, and Column K states whether the provider is eligible for DSH.

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R. 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 2018 subject to the policy for replaced devices offered without cost or with a credit.

CMS is revising the titles to MS-DRGs 023 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator), 469 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity with MCC or Total Ankle Replacement), and 470 (Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity without MCC). These MS-DRGs continue to be subject to the replaced devices offered without cost or with a credit policy, effective October 1, 2017.

LTCH PPS FY 2018 update

2018 LTCH PPS rates and factors

The FY 2018 LTCH PPS standard federal rates are located in Table 1E available on the FY 2018 Final Rule Tables webpage. Other FY 2018 LTCH PPS Factors are in MAC Implementation File 2 available on the FY 2018 MAC Implementation File webpage.

The LTCH PPS Pricer has been updated with the version 35.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2017, and on or before September 30, 2018.

A. Application of the site neutral payment rate

Section 1206(a) of Public Law 113–67 amended section 1886(m) of the 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 (80 FR 49601-49623). Section 15009 of the 21st Century Cures Act establishes a temporary exception to the application of the site neutral payment rate for certain spinal cord specialty hospitals, effective for discharges occurring during such LTCHs' cost reporting periods beginning during FY 2018 and FY 2019. Section 15010 of the 21st Century Cures Act establishes a temporary exception to the site neutral payment rate for certain severe wound discharges from certain LTCHs for cost reporting periods beginning during FY 2018. Information on the requirements implementing these temporary exceptions is available in CRs 10182 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1883OTN.pdf* and 10185 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1895OTN.pdf*, respectively.

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

Effective with **discharges occurring in LTCHs' cost reporting periods beginning on or after October 1, 2017** (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based on 100 percent of the site neutral payment rate for the discharge.

B. Changes to the short-stay outlier (SSO) payment adjustment

CMS is revising the payment formula used to determine payments for SSO cases beginning in FY 2018. This change is reflected in the LTCH PPS Pricer logic.

Effective for LTCH PPS discharges occurring on or after October 1, 2017, the adjusted payment for a SSO case is equal to the "blended payment amount option" under the previous SSO policy. That is, the adjusted payment for a SSO case is equal a blend of an amount comparable to what would otherwise be paid under the IPPS, computed as a per diem, and capped at the full IPPS DRG comparable amount, and the 120 percent LTC-DRG per diem amount. Note there has been no change in the definition of a SSO case (and it continues to be for discharges where the covered length of stay that is less than or equal to five sixths of the geometric average length of stay for each MS-LTC–DRG).

C. Changes to high-cost outlier (HCO) payments for LTCH PPS standard federal payment rate cases

When CMS implemented the LTCH PPS, it established a policy allowing for HCO payments to cases where the estimated cost of the case exceeds the outlier threshold. In general, the outlier threshold is the LTCH PPS payment plus a fixed-loss amount that is determined annually. Historically, CMS set this threshold so that aggregate estimated HCO payments accounted for 8 percent of the estimated total aggregate payments to LTCH PPS standard federal payment rate cases. In addition, to ensure these estimated HCO payments did not increase or decrease its estimated payments to LTCH PPS standard federal payment rates, CMS reduced the LTCH PPS standard federal payment rate by 8 percent.

Section 15004(b) of the 21st Century Cures Act (Pub. L. 114-255) requires that beginning in FY 2018, CMS continue to reduce the LTCH PPS standard federal payment rate by eight percent, but establish the HCO fixed-loss amount so that aggregate HCO payments are estimated to be

7.975 percent of estimated aggregate payments for

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standard Federal payment rate cases. Accordingly, the FY 2018 fixed-loss amount of $27,382 for LTCH PPS standard federal payment rate cases reflects this statutory requirement.

D. LTCH Quality Reporting (LTCHQR) Program

Section 3004(a) of the Affordable Care Act requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. For FY 2018, 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.

E. Provider-specific file (PSF)

The PSF required fields for all provider types which require a PSF is available in the *Medicare Claims Processing Manual*, Chapter 3, §20.2.3.1 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf*.

As noted above in section A.1., effective with discharges occurring in LTCHs' **cost reporting periods beginning on or after October 1, 2017** (FY 2018), the transitional blended payment rate for site neutral payment rate cases is no longer applicable, and such cases will be paid based 100 percent of the site neutral payment rate for the discharge. **MACs shall ensure that the FY beginning date field in the PSF (data element 4, position 25) is updated as applicable with the correct date.**

Table 8C contains the FY 2018 statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural LTCHs. Table 8C is available on the FY 2018 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2018, statewide average CCRs are used in the following instances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18).
2. LTCHs with a total CCR is in excess of 1.280 (referred to as the total CCR ceiling).
3. Any hospital for which data to calculate a CCR is not available.

Note: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in Section 150.24 of Chapter 3 of the *Medicare Claims Processing Manual*.

F. Cost of living adjustment (COLA) under the LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. The COLAs, which have been updated for FY 2018, and effective for discharges occurring on or after October 1, 2017, can be found in the FY 2018 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2018 MAC Implementation Files webpage. (Note that the same COLA factors are used under the IPPS and the LTCH PPS for FY 2018.)

G. 25-percent threshold policy

Section 15006 of the 21st Century Cures Act established a moratorium on the implementation of the 25-percent threshold policy until October 1, 2017. CMS also established an additional regulatory moratorium on the implementation of the 25-percent threshold policy effective until October 1, 2018. CMS codified changes to the regulations at § 412.538 in the FY 2018 final rule.

H. Average length of stay calculation

Section 15007 of the 21st Century Cures Act excluded Medicare Advantage and site neutral discharges from the calculation of the average length of stay for all LTCHs. CMS codified changes to the regulations at § 412.23(e)(3) in the FY 2018 final rule.

I. 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 of its DPP upon final settlement of the cost report.

J. Extended neoplastic disease care hospitals

Section 15008 of the 21st Century Cures Act removed certain hospitals, previously referred to as "subclause (II) LTCHs," from the IPPS-exclude hospital designation of an LTCH and created a new category of IPPS-excluded hospital for these entities, now referred to as "extended neoplastic disease care hospitals." As such, these hospitals are no longer subject to the LTCH PPS effective with for cost reporting periods beginning on or after January 1, 2015.

Section 15008 of the 21st Century Cures Act further specifies that, for cost reporting periods beginning on or after January 1, 2015, payment for inpatient operating costs for such hospitals is to be made as described in 42 CFR 412.526(c)(3), and payment for capital costs is to be made as described in 42 CFR 412.526(c)(4). (Note that any prior instructions issued by CMS for the payment of such hospitals redesignated by Section 15008 of the 21st Century Cures Act for cost reporting periods beginning on or after January 1, 2015 (for example, CR 9912), any references to "subclause (II) LTCHs" shall be read as "extended neoplastic disease care hospitals".)

Hospitals excluded from the IPPS

The update to extended neoplastic disease care hospital's target amount is the applicable annual rate-of-increase percentage specified in § 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2018 final rule, CMS established an update to an extended neoplastic disease care hospital's target amount for FY 2018 of 2.7 percent.

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October 2017 Update of the hospital outpatient prospective payment system

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers that submit claims to Medicare administrative contractors (MACs), including home health and hospice (HH&H) MACs, for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed

Change request (CR) 10236 which describes changes to the OPPS to be implemented in the July 2017 update. Make sure your billing staffs are aware of these changes.

Background

This recurring update notification describes changes to and billing instructions for various payment policies implemented in the October 2017 OPPS update. The October 2017 integrated outpatient code editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 10236. This recurring update notification applies to Chapter 4, Section 10.9.

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

Proprietary laboratory analyses (PLA) CPT® codes 0006U through 0017U, effective August 1, 2017

The American Medical Association CPT® editorial panel established 12 new PLA CPT® codes, specifically, CPT® codes 0006U through 0017U, effective August 1, 2017. Because the codes will be effective August 1, 2017, they were not included in the July 2017 OPPS update and are instead being including in the October 2017 update with an effective date of August 1, 2017.

Table 1 lists the long descriptors and status indicators for CPT® codes 0006U through 0017U.

For more information on OPPS status indicators "A" and "Q4", refer to OPPS Addendum D1 of the 2017 OPPS/ASC final rule for the latest definitions.

Table 1 – Proprietary laboratory analyses (PLA) CPT® codes effective August 1, 2017

CPT® code	Long descriptor	OPPS SI	OPPS APC
0006U	Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service	Q4	N/A
0007U	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service	Q4	N/A

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Additional information

The official instruction, CR 10273, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3858CP.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

September 11, 2017 Initial article released.

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CPT® code	Long descriptor	OPPS SI	OPPS APC
0008U	Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin	A	N/A
0009U	Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified	Q4	N/A
0010U	Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate	A	N/A
0011U	Prescription drug monitoring, evaluation of drugs present by LCMS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites	Q4	N/A
0012U	Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)	A	N/A
0013U	Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)	A	N/A

CPT® code	Long descriptor	OPPS SI	OPPS APC
0014U	Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome nextgeneration sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)	A	N/A
0015U	Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support	Q4	N/A
0016U	Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation	A	N/A
0017U	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected	A	N/A

CPT® codes 0006U through 0017U have been added to the October 2017 I/OCE with an effective date of August 1, 2017. These codes, along with their short descriptors and status indicators, are also listed in the October 2017 OPPS Addendum B.

Billing for peripheral artery disease (PAD) rehabilitation

Effective May 25, 2017, the Centers for Medicare

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& Medicaid Services (CMS) will pay for supervised exercised therapy (SET) for beneficiaries with intermittent claudication for the treatment of symptomatic peripheral artery disease. To implement this national coverage determination (NCD), CMS will pay separately for CPT® code 93668 under the hospital OPPS.

For purposes of Medicare coverage, services must meet all of the following eligibility criteria:

- Be consist of sessions lasting 30-60 minutes comprising a therapeutic exercise-training program for PAD in patients with claudication
- be conducted in a hospital outpatient setting, or a physician's office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Be under the direct supervision of a physician (as defined in 1861(r)(1)), physician assistant, or nurse practitioner/clinical nurse specialist (as identified in 1861(aa)(5)) who must be trained in both basic and advanced life support techniques.

Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments.

1. MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of time. A second referral is required for these additional sessions.
2. SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary physician.

For more information on this recent NCD, refer to the *Decision Memo on Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (CAG-00449N)*, which is available at *https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=287*.

Table 2 lists the long descriptor, status indicator, and APC assignment for CPT® code 93668. The payment amount for CPT® code 93668 is available in the October 2017 OPPS Addendum B.

Table 2 – Peripheral artery disease (PAD) rehabilitation

CPT® code	Long descriptor	OPPS SI	OPPS APC
93668	Peripheral arterial disease (pad) rehabilitation, per session	S	5733

New procedures requiring the insertion of a device

Since January 1, 2017, all new procedures requiring the insertion of an implantable medical device will be assigned a default device offset percentage of at least 41 percent, and thereby assigned device intensive status, until claims data is available. In certain rare instances, CMS may temporarily assign a higher offset percentage if warranted by additional information. In accordance with current Medicare policy, the following code requiring the insertion of a device (listed in Table 3, page 54) will be assigned device intensive status effective October 1, 2017. CMS notes that although HCPCS code C9747, was effective under the OPPS as of July 1, 2017, its device intensive designation is not effective until October 1, 2017.

Table 3 – New procedures requiring the insertion of a device (page 54)

Drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) effective October 1, 2017

Payment for separately payable non pass-through drugs, biologicals and therapeutic radiopharmaceuticals (status indicator "K") is made at a single rate of ASP + six percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, a single payment of ASP + six percent for pass-through drugs, biologicals and radiopharmaceuticals (status indicator "G") is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as ASP submissions become available. Updated payment rates effective October 1, 2017, and drug price restatements are available in the October 2017 update of the OPPS Addendum A and Addendum B at *https://www.cms.gov/HospitalOutpatientPPS/*.

b. Drugs and biologicals based on ASP methodology with restated payment rates

Some drugs and biologicals paid based on the ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html*.

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

c. Drugs and biologicals with OPPS pass-through status effective October 1, 2017

Four drugs and biologicals have been granted OPPS pass-through status effective October 1, 2017. These

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items, along with their descriptors and APC assignments, are identified in Table 4.

Table 4 – Drugs and biologicals with OPPS pass-through status effective October 1, 2017

HCPCS code	Short description	Long description	Oct 2017 OPPS SI	Oct 2017 OPPS APC
C9491	Injection, avelumab	Injection, avelumab, 10 mg	G	9491
C9492	Injection, durvalumab	Injection, durvalumab, 10 mg	G	9492
C9493	Injection, edaravone	Injection, edaravone, 1 mg	G	9493
C9494	Injection, ocrelizumab	Injection, ocrelizumab, 1 mg	G	9494

d. New modifier for biosimilar biological product

Q5102 can be reported with either the existing modifier ZB or new modifier ZC effective July 1, 2017, see Table 5, page 54.

Table 5 – Biosimilar biological product payment and required modifiers (page 54)

e. New Flu Vaccine

The existing influenza vaccine CPT® code 90674 (Cciiv4 vaccine, no preservative, 0.5 ml, intramuscular) with trade name Flucelvax Quadrivalent was effective January 1, 2017, and is a preservative-free and antibiotic-free vaccine. A new preservative, antibiotic-free influenza vaccine CPT® code with the same trade name, Flucelvax Quadrivalent, will be effective on January 1, 2018. For the period between August 1, 2017, and December 31, 2017, Flucelvax Quadrivalent Preservative can be reported as Q2039. The permanent CPT® code for the Flucelvax Quadrivalent preservative influenza vaccine will be released on a later date, see Table 6, page 54.

Table 6 – Billing for preservative and preservative-free Flucelvax Quadrivalent influenza vaccine (page 54)

Upper eyelid blepharoplasty and blepharoptosis repair

As indicated in Chapter VIII of the 2017 *National Correct Coding Initiative (NCCI) Policy Manual* for Medicare Services, CMS payment policy does not allow separate payments for a blepharoptosis procedure (CPT® code 67901-67908) and a blepharoplasty procedure (CPT® codes 15822-15823) on the ipsilateral upper eyelid. Under this policy, any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery was considered a part of the blepharoptosis surgery. This instruction was clarified in the July 2016 hospital OPPS update change request (CR) (transmittal 3557, CR 9658 dated July 1, 2016) and the July 2016 OPPS *MLN Matters*® article MM9658, available at *https://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9658.pdf*.

- However, effective October 1, 2017, CMS is revising this policy to allow either cosmetic or medically necessary blepharoplasty to be performed in conjunction with a medically necessary upper eyelid blepharoptosis surgery. Specifically, physicians may receive payment for a medically necessary upper eyelid blepharoptosis from Medicare even when performed with separate payment for the following:
- Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery
- Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed
- Performing a blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the blepharoplasty
- Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)
- Billing for two procedures when two surgeons divide the work of a blepharoplasty performed with a blepharoptosis repair
- Using modifier 59 to unbundle the blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities.
- Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery
- In the rare event that a blepharoplasty is performed on one eye and a blepharoptosis repair is performed on the other eye, the services must each be billed with the appropriate RT or LT modifier.

Transuretheral waterjet prostate ablation procedure

On June 5, 2017, the Investigational Device Exemption (IDE) study associated with the “Waterjet Ablation Therapy for Endoscopic Resection of Prostate Tissue II” met CMS’s standards for coverage. The procedure associated with this study is currently described by CPT® code 0421T. Based on the recent Medicare coverage of the IDE study, CMS is revising the OPPS status indicator (SI) for CPT® code 0421T from “E1” (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to “J1” (Hospital Part B services paid through a comprehensive APC) and assigning the code to APC 5374 (Level 4 Urology and Related Services).

The SI and APC revision will be added to the January 2018 IOCE release with an effective date of June 5, 2017, which is the date of the Medicare approval for coverage of the IDE study.

Table 7 lists the long descriptor, status indicator, and APC assignment for CPT® code 0421T. The October

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2017 national payment rate for APC 5374 is $2,542.56. However, as previously stated, payment for claims involving CPT® code 0421T will not begin to be processed until January 1, 2018.

For more information on this approved Medicare IDE study, refer to study title "Waterjet Ablation Therapy for Endoscopic Resection of Prostate Tissue II," which can be found on the CMS IDE Studies website at: *https://www.cms.gov/Medicare/Coverage/IDE/Approved-IDE-Studies.html*.

For more information on Medicare's coverage related to IDE studies, refer to this CMS website: *https://www.cms.gov/Medicare/Coverage/IDE/index.html*.

Table 7 – Transuretheral waterjet prostate ablation procedure

CPT® code	Long description	OPPS SI	OPPS APC
0421T	Transurethral waterjet ablation of prostate, including control of postoperative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)	J1	5374

Coverage determinations

As a reminder, the fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare administrative contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 10236, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3864CP.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
September 15, 2017	The article was revised to reflect an updated change request (CR) that updated the policy section (added "Transuretheral waterjet prostate ablation procedure") that also includes information on the revised OPPS status indicator and APC for CPT® code 0421T. It also corrected an error to the OPPS status indicator for Q5102 in Table 5. In addition, a new Table 7 was added.
August 29, 2017	Initial article released

MLN Matters® Number: MM10236
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Related CR Transmittal Number: R3864CP
Related Change Request (CR) Number: 10236
Effective Date: October 1, 2017
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Table 3 — New procedures requiring the insertion of a device

HCPCS code	Long descriptor	Effective date	October 2017 OPPS SI	October 2017 OPPS APC	2017 OPPS payment rate	2017 device offset
C9747	Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance	10-01-2017	J1	5376	$7,452.66	$3,055.60

Table 5 – Biosimilar biological product payment and required modifiers

HCPCS code	Short descriptor	Long descriptor	SI	APC	HCPCS code effective date	Modifier	Modifier Effective Date
Q5102	Injection, infliximab biosimilar	Injection, Infliximab, Bio similar, 10 mg	G	1847	04/05/2016	ZB – Pfizer/ Hospira	04/01/2016
Q5102	Injection, infliximab biosimila	Injection, Infliximab, Biosimilar, 10 mg	G	1847	04/05/2016	ZC – Merck/ Samsung Bioepis	07/01/2017

Table 6 – Billing for preservative and preservative-free Flucelvax Quadrivalent influenza vaccine

Vaccine type	HCPCS code	Short descriptor	Long descriptor	OPPS SI
Flucelvax Quadrivalent Preservative-Free and Antibiotic-Free Flu Vaccine	90674	Cciiv4 vaccine, no preservative, 0.5 ml, intramuscular	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	L
Flucelvax Quadrivalent Preservative Flu Vaccine	Q2039	Cciiv4 vaccine, nos, intramuscular	Influenza virus vaccine, not otherwise specified	L

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*.

October 2017 integrated outpatient code editor specifications version 18.3

Provider types affected

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

Provider action needed

Change request (CR) 10230 provides the integrated outpatient code editor (I/OCE) instructions and specifications that will be used under the outpatient prospective payment system (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the home health PPS or to a hospice patient for the treatment of a non-terminal illness. This update relates to Chapter 4, Section 40.1 of the *Medicare Claims Processing Manual* (Pub. 100-04). Make sure your billing staffs are aware of these updates.

Background

CR 10230 informs MACs, as well as the fiscal intermediary shared system (FISS) maintainer that the I/OCE is being updated for October 1, 2017. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.

The I/OCE specifications will be posted at *https://www.cms.gov/OutpatientCodeEdit/*.

The following table summarizes the modifications of the I/OCE for the October 2017 v18.3 release. Note that some I/OCE modifications may be retroactively added to prior releases. If so, the retroactive date appears in the "Effective date" column.

Note: Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the "Effective date" column.

Effective date	Edits affected	Modification
10/1/2017	1, 2, 3, 5, 86	Updated diagnosis code editing for validity, age, gender and manifestation based on the FY 2018 ICD-10-CM code revisions to the Medicare code editor (MCE).

Effective date	Edits affected	Modification
10/1/2017	29	Updated the mental health diagnosis list based on the FY 2018 ICD-10-CM code revisions.
10/1/2017	95	Modify the effective date for edit 95 to 10/1/2017.
4/1/2017	30, 95	Update the list of add-on procedure codes that are not counted towards the daily and weekly requirements for number of partial hospitalization program (PHP) services. Procedure codes 90833, 90836 and 90838 are removed from the list; 90785 remains (see special processing logic, Appendix C-a flowchart and Appendix O of CR10230).

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Effective date	Edits affected	Modification
7/1/2017	22	Add ZC (Merck/ Samsung Bioepis) to the list of valid modifiers.
7/1/2017	94	Add modifier ZC as a biosimilar manufacturer modifier applicable for HCPCS Q5102.
10/1/2016	99	Add HCPCS J2505 (Injection, pegfilgrastim 6mg) to the list of HCPCS excepted from requiring an OPPS procedure on the same claim (see special processing logic).
7/1/2017	41, 65	Add new revenue code 1006 to the list of valid revenue codes and to the list of revenue codes not recognized by Medicare.
10/1/2017		Update the following lists for the release (see quarterly data files): ▪ Edit 99 exclusion list (add new codes to exception ▪ Comprehensive ambulatory payment classification (APC) ranking ▪ Comprehensive APC code pairs (correction to two APC pairs missing complexity-adjusted APC assignment retroactive for 2016 service dates) ▪ New data file report for comprehensive APCs (includes list of procedures, rank and flag for eligibility of complexity-adjusted APC) ▪ Device-procedure list (edit 92) ▪ Terminated device-procedures for device credit (device offset amount corrections; updated code ▪ Non-standard CT scan (updated code list)

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Effective date	Edits affected	Modification
8/1/2017	68	Implement National Coverage Determination (NCD) mid-quarter effective editing for procedure codes 0006U, 0007U, 0008U, 0009U, 0010U, 0011U, 0012U, 0013U, 0014U, 0015U, 0016U, 0017U.
5/25/2017	68	Implement NCD mid-quarter effective editing for procedure code 93668.
4/3/2017	68	Implement NCD mid-quarter effective editing for HCPCS A4575 and E0446.
10/1/2017		Make all HCPCS/ APC/SI changes as specified by CMS (quarterly data files).
10/1/2017	20, 40	Implement version **23.3** of the NCCI (as modified for applicable outpatient institutional providers).

Additional information

The official instruction, CR 10230, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3852CP.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 29, 2017	Initial article released

MLN Matters® Number: MM10230
Related Change Request (CR) Number: 10230
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Inpatient rehabilitation facility annual update: Prospective payment system changes

Provider types affected

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

Provider action needed

This article is based on change request (CR) 10125, which notifies you that a new IRF PRICER software package will be released prior to October 1, 2017, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2017, through September 30, 2018. MACs will install and pay IRF claims with the FY 2018 IRF prospective payment system (PPS) PRICER for discharges on or after October 1, 2017.

Background

On August 7, 2001, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a final rule that established the PPS for IRFs, as authorized under Section1886 (j) of the Social Security Act (the Act). In that final rule, CMS set forth per discharge federal rates for federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by Section 1886 (j)(3)(C) of the Act.

Key points for FY2018 IRF PPS

The FY 2018 IRF PPS final rule, issued July 31, 2017, sets forth the prospective payment rates applicable for IRFs for FY 2018. A new IRF PRICER software package will be released prior to October 1, 2017, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2017 through September 30, 2018.

1. Phase out of rural adjustment

CMS has implemented a three-year budget neutral phase out of the rural adjustment for those IRFs that meet the definition in Section 412.602 as rural in FY 2015 and became urban under the FY 2016 CBSA-based

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designations. CMS will afford existing IRFs designated in FY 2015 as rural IRFs (pursuant to Section 412.602) and re-designated as an urban facility in FY 2016 (pursuant to Section 412.602), a three-year phase out in order to mitigate the payment effect upon a rural facility that is re-designated as an urban facility (effective FY 2016) and thereby loses the rural adjustment of 1.149. This is the third year of the phase out of rural adjustment.

2. Removal of 25 percent payment penalty

3. PRICER updates for IRF PPS FY 2018 (October 1, 2017 – September 30, 2018)

PRICER update	Amount
Standard federal rate	$15,838
Adjusted standard federal rate	$15,524
Fixed loss amount	$8,679
Labor-related share	0.707
Non-labor related share	0.293
Urban national average cost to charge ratio (CCR)	0.416
Rural national average CCR	0.518
Low-income patient (LIP) adjustment	0.3177
Teaching adjustment	1.0163
Rural adjustment	1.149

Section 1886(j)(7)(A)(i) of the Act requires application of a two percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. The mandated reduction will be applied in FY 2018 for IRFs that failed to comply with the data submission requirements during the data collection period January 1, 2016, through December 31, 2016. Thus, in compliance with 1886(j)(7)(A)(i) of the Act, we will apply a two percentage point reduction to the applicable FY 2018 market basket increase factor (1.0 percent) in calculating an adjusted FY 2018 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.

Application of the two percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

The adjusted FY 2018 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from January 1, 2016, through December 31, 2016 will be $15,524.

Additional information

The official instruction, CR 10125, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3849CP.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 29, 2017	Initial article released.

MLN Matters® Number: MM10125
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Related CR Transmittal Number: R3849CP
Related Change Request (CR) Number: CR 10125
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Implementation Date: October 2, 2017

Internet-based PECOS training by appointment

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. Please email *elearning@fcso.com* to request an appointment.

October 2017 quarterly update to the Medicare physician fee schedule database

Provider type affected

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

Provider action needed

Change request (CR) 10222 amends payment files that were issued to the MACs based upon the 2017 Medicare physician fee schedule (MPFS) final rule. Please make sure your billing staffs are aware of these changes.

Background

Payment files are issued to the MACs based upon the 2017 MPFS final rule, published in the *Federal Register* November 15, 2016, to be effective for services furnished between January 1, 2017, and December 31, 2017. Section 1848(c)(4) of the Social Security Act authorizes the Secretary of the Department of Health & Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians' services.

This article presents a summary of the changes for the October update to the 2017 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2017.

CPT®/ HCPCS & mod	Action
20245	Pre op = 0, Intra op = 0, Post op = 0
36473	Bilateral surg = 1
64897	Post op = 0.13
93668	Status indicator = C for dates of service 1/1/17 or after
A4575	Status indicator = X for dates of service 4/3/17 or after

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

CPT® code	Short descriptor	Long descriptor
0006U	RX MNTR 120+ DRUGS & SBSTS	Prescription drug monitoring, 120 or more drugs and substances, definitive tandem mass spectrometry with chromatography, urine, qualitative report of presence (including quantitative levels, when detected) or absence of each drug or substance with description and severity of potential interactions, with identified substances, per date of service
0007U	RX TEST PRSMV UR W/ DEF CONF	Drug test(s), presumptive, with definitive confirmation of positive results, any number of drug classes, urine, includes specimen verification including DNA authentication in comparison to buccal DNA, per date of service
0008U	HPYLORI DETCJ ABX RSTNC DNA	Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin embedded or fresh tissue, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline and rifabutin
0009U	ONC BRST CA ERBB2 AMP/ NONAMP	Oncology (breast cancer), ERBB2 (HER2) copy number by FISH, tumor cells from formalin fixed paraffin embedded tissue isolated using image-based dielectrophoresis (DEP) sorting, reported as ERBB2 gene amplified or non-amplified
0010U	NFCT DS STRN TYP WHL GEN SEQ	Infectious disease (bacterial), strain typing by whole genome sequencing, phylogenetic-based report of strain relatedness, per submitted isolate

See **MPFSDB**, next page

MPFSDB

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CPT® code	Short descriptor	Long descriptor
0011U	RX MNTR LC-MS/ MS ORAL FLUID	Prescription drug monitoring, evaluation of drugs present by LC-MS/MS, using oral fluid, reported as a comparison to an estimated steady-state range, per date of service including all drug compounds and metabolites
0012U	GERMLN DO GENE	Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)
0013U	ONC SLD ORG NEO GENE	Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)
0014U	HEM HMTLMF NEO GENE	Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)
0015U	RX METAB ADVRS RX RXN DNA	Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support
0016U	ONC HMTLMF NEO RNA BCR/ABL1	Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation
0017U	ONC HMTLMF NEO JAK2 MUT DNA	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected

The short descriptors for the technical and professional components of the following codes were not displaying properly on the MPFS and did not match the HCPCS file. The global procedure accurately reflects the short descriptor from the HCPCS file. This display issue has been corrected and the short descriptors for the technical and professional components now read as follows on the MPFS:

92978 – TC Endoluminl ivus oct c 1st

92978 – 26 Endoluminl ivus oct c 1st

92979 – TC Endoluminl ivus oct c ea

92979 – 26 Endoluminl ivus oct c ea

G0202 – TC Scr mammo bi incl cad

G0202 – 26 Scr mammo bi incl cad

G0204 – TC Dx mammo incl cad bi

G0204 – 26 Dx mammo incl cad bi

G0206 – TC Dx mammo incl cad uni

G0206 – 26 Dx mammo incl cad uni

Providers should be aware that MACs do not need to search their files to either retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 10222, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3838CP.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 29, 2017	Initial article released.

MLN Matters® Number: MM10222
Related CR Release Date: August 25, 2017
Related CR Transmittal Number: R3838CP
Related Change Request (CR) Number: 10222
Effective Date: January 1, 2017
Implementation Date: October 2, 2017

October quarterly update for 2017 DMEPOS fee schedule

Provider type affected

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

Provider action needed

Change request (CR) 10248 provides instructions regarding the October quarterly update for the 2017 DMEPOS and parenteral and enteral nutrition (PEN) fee schedules and the October 2017 DMEPOS rural ZIP code file containing the Quarter 4, 2017, rural ZIP code changes. 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 schedule is updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes, and the quarterly update process for the DMEPOS fee schedule is covered 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 DMEPOS and surgical dressings by the Social Security Act, Section 1834(a), (h), and (i) at *https://www.ssa.gov/OP_Home/ssact/title18/1834.htm*. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR *§414.102* for PEN, splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, the Social Security Act (Section 1834(a)(1)(F)(ii)) mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (Section 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 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9642.pdf*, 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.

Effective with the October update, code K0861 RR KF is removed from the fee schedule file.

The October 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*.

Additional information

The official instruction, CR 10248, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2017Downloads/R3859CP.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
September 12, 2017	Initial article released

MLN Matters® Number: MM10248
Related CR Release Date: September 8, 2017
Related CR Transmittal Number: R3859CP
Related Change Request (CR) Number: CR 10248
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

Influenza vaccine payment allowances -annual update for 2017-2018 season

Provider types affected

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

Provider action needed

Change request (CR) 10224 informs MACs about the payment allowances for seasonal influenza virus vaccines, which are updated on August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved after the release of CR 10224 at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*. Make sure your billing staffs are aware that the payment allowances are being updated.

Background

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the average wholesale price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

The Medicare Part B payment allowances for the following *Current Procedural Terminology* (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2017-July 31, 2018:

- CPT® 90653 Payment allowance is $50.217.
- CPT® 90655 Payment allowance is pending.
- CPT® 90656 Payment allowance is $19.247.
- CPT® 90657 Payment allowance is pending.
- CPT® 90661 Payment allowance is pending.
- CPT® 90685 Payment allowance is $21.198.
- CPT® 90686 Payment allowance is $19.032.
- CPT® 90687 Payment allowance is $9.403.
- CPT® 90688 Payment allowance is $17.835.
- HCPCS Q2035 Payment allowance is $17.685.
- HCPCS Q2036 Payment allowance is pending.
- HCPCS Q2037 Payment allowance is $17.685.
- HCPCS Q2038 Payment allowance is pending.

Payment for the following CPT® or HCPCS codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary, for the

effective dates of August 1, 2017 -July 31, 2018:

- CPT® 90630 Payment allowance is $20.343.
- CPT® 90654 Payment allowance is pending.
- CPT® 90662 Payment allowance is $49.025.
- CPT® 90672 Payment allowance is pending.
- CPT® 90673 Payment allowance is $40.613.
- CPT® 90674 Payment allowance is $24.047.
- CPT® 90682 Payment allowance is $46.313. (new code)
- CPT® 90756 Payment allowance is $22.793. **Effective dates**: 1/1/2018-7/31/2018 (**Note**: Providers and Medicare administrative contractors shall use HCPCS Q2039 for dates of service from 8/1/2017 – 12/31/2017. See special note under HCPCS Q2039 for payment amounts for this product prior to 1/1/2018.)
- HCPCS Q2039 Flu vaccine adult - not otherwise classified. Payment allowance is to be determined by your MAC with effective dates of 8/1/2017 -7/31/2018.

  Special note: Until CPT® code 90756 is implemented on 1/1/2018, Q2039 shall be used for products described by the following language: influenza virus vaccine, quadrivalent(ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. The payment allowance for these products, effective for dates of service 8/1/2017 -12/31/2017 is $22.793.

CMS will post payment limits for influenza vaccines that are approved after the release date of CR 10224 on the CMS Seasonal Influenza Vaccines Pricing webpage at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* as information becomes available. Effective dates for these vaccines shall be the date of Food and Drug Administration (FDA) approval.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files.

See **FLU**, next page

Annual clotting factor furnishing fee update 2018

Provider type affected

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

Provider action needed

Change request (CR) 10254 announces the clotting factor furnishing fee for 2018 is $0.215 per unit. Make sure that your billing staffs are aware of this update to the annual clotting factor furnishing fee for 2018.

Background

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the average sales price (ASP) Medicare Part B drug pricing file or the not otherwise classified (NOC) pricing file, the MACs make payment for the clotting factor as well as payment for the furnishing fee. For dates of service from January 1, 2018, through December 31, 2018, the clotting factor furnishing fee of $0.215 per unit is added to the payment limit for the clotting factor.

Additional information

The official instruction, CR 10254, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3862CP.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
September 15, 2017	Initial article released.

MLN Matters® Number: MM10254
Related Change Request (CR) Number: CR10254
Related CR Release Date: September 15, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3862CP
Implementation Date: January 2, 2018

FLU

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Providers should note that:

- All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- The annual Part B deductible and coinsurance amounts do not apply.
- Your MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 10224, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3837CP.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 18, 2017	Initial article released.

MLN Matters® Number: MM10224
Related CR Release Date: August 18, 2017
Related CR Transmittal Number: R3837CP
Related Change Request (CR) Number: CR 10224
Effective Date: August 1, 2017
Implementation Date: No later than October 2, 2017

ESRD low volume adjustment – annual requirement

End-stage renal disease (ESRD) providers may be eligible to receive a low volume payment adjustment to their rate if they meet certain criteria as outlined in this article.

ESRD providers that are currently receiving the low volume adjustment are required to submit an annual attestation prior to November 1 preceding the next payment year. Attestations will not be accepted after the November 1 deadline.

Note: Attestations can be accepted for individual ESRD facilities only. Each facility must submit its own attestation. Master lists of ESRD facilities that are owned by one organization will not be accepted. Each facility must indicate on its own attestation that it believes it is eligible for the low-volume payment adjustment.

If a provider determines that they are no longer qualified to receive the low volume facility adjustment based on the following criteria, they must notify us. If we discover that claims have received the low volume adjustment in error, we have six months to reprocess to remove the low volume adjustment.

Low volume criteria:

1. The facility has furnished less than 4,000 treatments in each of the three years preceding the payment year.

Note: The three eligibility years are based on cost reporting years.

Previously, eligibility for ESRD facilities that opened on January 1, 2011, and after were assessed by aggregating their treatments with other facilities that was within a 25 road mile radius and is under common ownership.

For CY 2016, the Centers for Medicare & Medicaid Services (CMS) removed grandfathering from these criteria and revised the geographic proximity criterion from 25 road miles to five road miles. These changes exclude facilities of common ownership that are located within five miles of one another, regardless of when these facilities opened.

2. The facility has not opened, closed, or had a change of ownership that resulted in a change in PTAN in the three years preceding the payment year.

   *Please review CR 8898 for changes regarding the 4,000 treatment count for hospitals that have multiple locations and changes to the 12-month cost report rule for provider's that have had a change of ownership with no change in provider transaction access number (PTAN).

   Note: The low volume adjustment applies only for dialysis treatments provided to adults (18 years or older).

Documentation needed:

To receive the low volume adjustment, ESRD providers must submit an attestation signed by the managing director or official of their organization by November 1 preceding the next ESRD prospective payment system (PPS) payment year that includes the following information:

- Provider name
- Medicare provider number (PTAN) and national provider identifier (NPI)
- Provider's physical address (including building/suite/room number, etc.)
- ESRD certification date
- Is your facility a free standing facility or hospital based?
- Has the facility opened, closed, or had a change in ownership in the three years preceding the payment year?
- If there was a change of ownership, did it result in a change of PTAN?
- Is this ESRD part of common ownership?
- If yes, please provide the organization's name
- Distance between ESRD provider and nearest commonly owned ESRD providers (within five miles or less)
- Treatment counts for other commonly owned ESRD providers that are within five miles or less of each other.
- Provider contact name (please print)
- Provider contact phone number
- Provider contact email address
- Director or official signature

In addition, providers should submit cost report worksheet C (for free standing ESRD providers) and cost report worksheet I-4 (for hospital based ESRD providers) for the three 12 month cost reporting periods immediately preceding the ESRD PPS payment year. For ESRD providers with a December 31 fiscal year end, please provide a projection of the number of treatments for the third eligibility year. Once the current year December 31 cost report is received, treatment numbers will be verified.

This noti ication should be sent to:

Kathy Towns, Senior Auditor

First Coast Service Options, Inc
532 Riverside Ave ROC-3C
Jacksonville, FL 32202

Phone: (904) 791-6570
Email: *mailto:Kathy.towns@fcso.com*

CMS launches Jimmo Settlement Agreement webpage

Looking for information about the Jimmo Settlement Agreement? Visit the new Jimmo Settlement Agreement webpage at *https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html* for:

- Background on the settlement
- Links to resources
- Frequently asked questions (FAQs)

The Centers for Medicare & Medicaid Services (CMS) reminds the Medicare community of the Jimmo Settlement Agreement (January 2013), which clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare's skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met). Specifically, the Jimmo Settlement required manual revisions to restate a "maintenance coverage standard" for both skilled nursing and therapy services under these benefits:

- Skilled nursing services would be covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.
- Skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.

The Jimmo Settlement may reflect a change in practice for those providers, adjudicators, and contractors who may have erroneously believed that the Medicare program covers nursing and therapy services under these benefits only when a beneficiary is expected to improve. The Settlement is consistent with the Medicare program's regulations governing maintenance nursing and therapy in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and nursing and therapy in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.

Screening for the human immunodeficiency virus infection

***Note**: This article was revised August 17, 2017, to reflect a revised change request (CR) 9980 issued August 16. In the article, the CR release date, transmittal number, and the web address for accessing CR 9980 are revised. All other information remains the same. This information was previously published in the June 2017 Medicare A Connection, page 1.*

Provider type affected

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

Provider action needed

CR 9980 informs MACs that they shall recognize the specified HCPCS codes for services related to the Screening for the human immunodeficiency virus (HIV) infection. Make sure that your billing staffs are aware of these codes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued CR 9403 (transmittal 3461), effective April 13, 2015, for screening for HIV infection. The guidelines are based on strong recommendations by the U.S. Preventive Services Task Force published in April 2013. The recommendations provide guidelines for screening various age groups based on risk of infection as well as for pregnant women.

Effective for claims with dates of service on or after April 13, 2015, MACs will recognize the following Healthcare Common Procedure Coding System (HCPCS) codes for claims processed on or after October 2, 2017: G0432, G0433, and G0435. Testing frequency and other functions for these codes is the same as for those listed in CR9403. A related *MLN Matters*® article is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9403.pdf*.

HCPCS code	Descriptor
G0432	Infectious agent antibody detection by enzyme Immune assay (EIA) technique, qualitative or Semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening.
G0435	Infectious agent antibody detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.

See **HIV**, next page

HIV

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Billing requirements

Your MAC will calculate the next eligible date for HIV screening to include HCPCS codes G0432, G0433, and G0435 to be included with G0475 and based on effective date of April 13, 2015.

The next eligible date will be displayed on all of Medicare's common working file (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN). This includes MBD and NGD extract records.

When there is no next eligible date, the CWF provider query screens will display this information in the date field to indicate why there is not a next eligible date.

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS code G0475, G0432, G0433, or G0435 is submitted without the required HIV primary diagnosis codes of Z11.4, OR

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS 80081 is submitted with one of the following secondary diagnosis codes denoting pregnancy, but the required HIV primary diagnosis code of Z11.4 is not present:

- 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, O09.93

The claim line item will be denied. In denying the line, MACs will use either:

- **Claim adjustment reason code (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. or
- **CARC 11** - This diagnosis is inconsistent with the procedure. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks code (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)

Medicare will create a new consistency edit to deny when the incoming HUOP or HUBC claim line having either the HIV HCPCS codes G0475, G0432, G0433, G0435, or the CPT® code 80081 is submitted with one of the pregnancy secondary diagnosis codes, but the sex code on the claim indicates 'male.' The secondary diagnosis codes indicating pregnancy are:

- 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, O09.93

In denying a line for this reason, MACs will use:

- **CARC 7** - The procedure/revenue code is inconsistent with the patient's gender. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Group code** CO

Medicare systems will create a consistency edit to not allow place of service (POS) other than 11 (Office) or 81 (independent lab for the HIV screenings HCPCS G0475, G0432, G0433, and 'G0435' effective with dates of service on or after April 13, 2015. If a POS other than 11 or 81 is on the claim, the MAC will deny the line item, using:

- **CARC 171** - Payment is denied when performed/ billed by this type of provider in 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 this place of service.
- **Group code** CO

Medicare systems will create a consistency edit to not allow type of bill (TOB) other than 12x, 13x, 14x, 22x, 23x, and 85x for the HIV screening HCPCS G0475, G0432, G0433, and G0435.

Additional information

The official instruction, CR 9980, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3835CP.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

- June 6, 2017 – Initial article released.
- August 17, 2017 – Article revised to reflect revised CR 9980. In the article, the CR release date, transmittal number, and the web address for accessing CR 9980 are revised. All other information remains the same.

MLN Matters® Number: MM9980
Related Change Request (CR) #: CR 9980
Related CR Release Date: August 16, 2017
Effective Date: April 13, 2015
Related CR Transmittal #: R3835CP
Implementation Date: October 2, 2017

Manual update to restore multiple patients on one trip instructions

Provider type affected

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

Provider action needed

Change request (CR) 10245 alerts providers that instructions in Section 30.1.2 of Chapter 15 – Ambulance, concerning *Multiple Patients on One Trip* were inadvertently omitted from the current version of the *Medicare Claims Processing Manual*. CR 10245 restores the missing instructions to Section 30.1.2. Be aware that this CR 10245 contains no policy changes but does update the manual section.

Background

The omitted language that is being added back into the manual is as follows:

Ambulance suppliers submitting a claim using the ASC X12 professional format or the CMS-1500 paper form for an ambulance transport with more than one Medicare patient onboard must use the "GM" modifier ("Multiple Patients on One Ambulance Trip") for each service line item. In addition, suppliers are required to submit documentation to A/B MACs (Part B) to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim numbers (HICN) for each Medicare beneficiary.

Ambulance claims submitted on or after January 1, 2011, in version 5010 of the ASC X12 837 professional claim format require the presence of a diagnosis code and the absence of diagnosis code will cause the ambulance claim to not be accepted into the claims processing system. The presence of a diagnosis code on an ambulance claim is not required as a condition of ambulance payment policy. The adjudicative process does not take into account the presence (or absence) of a diagnosis code but a diagnosis code is required on the ASC X12 837 professional claim format.

Additional information

The official instruction, CR 10245, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3855CP.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
September 1, 2017	Initial article released.

MLN Matters® Number: MM10245
Related CR Release Date: September 1, 2017
Related CR Transmittal Number: R3855CP
Related Change Request (CR) Number: 10245
Effective Date: October 2, 2017
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Medicare A Connection subscription

Medicare A Connection is published monthly and is available online in both English and Spanish.

Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published in the current fiscal year.

To order an annual subscription, complete the *Medicare A Connection Subscription Form*, ***located here***.

Upcoming provider outreach and educational events

Medicare Speaks 2017 Jacksonville

Date: Tuesday-Wednesday, October 17-18
Time: 7:30 a.m.-4:15 p.m.
Type of Event: Face-to-face
https://medicare.fcso.com/Medicare_Speaks/0371641.asp

How to register for PECOS I&A system (A/B)

Date: Wednesday, October 25
Time: 11:30 a.m.-12:30 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0386241.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 August 24, 2017

MLN Connects® for August 24, 2017
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News & Announcements

- CMS Launches Jimmo Settlement Agreement webpage

Provider Compliance

- CMS Provider Minute: Preventive Services Video

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
- Qualified Medicare Beneficiary Program Billing Rules Call — September 19
- Reporting Hospice Quality Data: Tips for Compliance Call — September 20
- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28
- Comparative Billing Report on Modifier 25 Dermatology Webinar — October 11

Medicare Learning Network Publications & Multimedia

- Mass Immunizers and Roster Billing Booklet — revised
- Beneficiaries in Custody under a Penal Authority Fact Sheet — revised
- Chronic Care Management Services Changes for 2017 Fact Sheet — reminder

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

MLN Connects® for August 31, 2017

MLN Connects® for August 31, 2017
View this edition as a PDF

News & Announcements

- New PEPPER Available for Short-term Acute Care Hospitals
- Hospice Compare Update Document Available
- Participate in Quality Payment Program Website Testing
- Departmental Appeals Board: Submit Feedback
- Correction to QRDA III Implementation Guide for Eligible Clinicians and Eligible Professionals

Provider Compliance

- Billing For Stem Cell Transplants

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
- Qualified Medicare Beneficiary Program Billing Requirements Call — September 19
- Reporting Hospice Quality Data: Tips for Compliance Call — September 20
- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28

Medicare Learning Network Publications & Multimedia

- IMPACT Act Call: Audio Recording and Transcript – new
- A Physician's Guide to Medicare Part D Medication Therapy Management Programs MLN Matters® article – revised
- Preventive Services Poster Educational Tool – revised
- Medicare Costs at a Glance: 2017 Educational Tool – reminder
- Suite of Products & Resources for Rural Health Providers Educational Tool – reminder
- Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet – reminder
- Physician Fee Schedule Fact Sheet – reminder
- Telehealth Services Fact Sheet – reminder
- Transitional Care Management Services Fact Sheet – reminder
- Federally Qualified Health Center Fact Sheet – reminder
- Rural Health Clinic Fact Sheet – reminder
- Medicare Home Health Benefit Booklet – reminder
- Critical Access Hospital Booklet – reminder

MLN Connects® for September 7, 2017

MLN Connects® for September 7, 2017
View this edition as a PDF

News & Announcements

- Hospice Provider Preview Reports Available through September 28
- IRF and LTCH Provider Preview Reports: Review by September 30
- IRF and LTCH Compare Quarterly Refresh
- Mapping Medicare Disparities Tool: 2017 Enhancements Released
- 2015 Inpatient and Outpatient Hospital Utilization and Payment Data Available
- Healthy Aging® Month: Discuss Preventive Services with your Patients

Provider Compliance

- Lumbar Spinal Fusion CMS Provider Minute Video — reminder

Claims, Pricers & Codes

- October 2017 Average Sales Price Files Available

Upcoming Events

- Overview of MIPS for Small, Rural, and Underserved Practices Webinar — September 8
- New Medicare Card Project: Clearinghouses and Vendors Special Open Door Forum — September 12
- Qualified Medicare Beneficiary Program Billing Requirements Call — September 19
- Reporting Hospice Quality Data: Tips for Compliance Call — September 20
- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28

Medicare Learning Network Publications & Multimedia

- Medicare Diabetes Prevention Program: Audio Recording and Transcript — new

MLN Connects® for September 14, 2017

MLN Connects® for September 14, 2017

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News & Announcements

- Quality Payment Program: New Resources Available
- September is Prostate Cancer Awareness Month

Provider Compliance

- Billing for Ambulance Transports — reminder

Upcoming Events

- Qualified Medicare Beneficiary Program Billing Requirements Call — September 19
- Reporting Hospice Quality Data: Tips for Compliance Call — September 20
- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28

Medicare Learning Network Publications & Multimedia

- Office of Inspector General Reports Highlight Hospital Billing Issues *MLN Matters*® article — new
- PECOS for DMEPOS Suppliers Booklet — reminder
- Medicare Enrollment Resources Educational Tool — reminder

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MLN Connects® for September 21, 2017

MLN Connects® for September 21, 2017

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News & Announcements

- Transition to New Medicare Numbers and Cards
- 2016 PQRS Feedback Reports and Annual QRURs Available
- Hospice Provider Preview Reports Available through September 28
- IRF and LTCH Provider Preview Reports: Review by September 30
- CMS Innovation Center New Direction RFI: Submit Comments by November 20
- DME Appeals Demonstration: Respond to Reopening Document Request Letters
- Chronic Care Management: Connected Care Videos
- Quality Payment Program: Hardship Exception Application for 2017 Transition Year Available
- Hospital Quality Reporting Programs: eCQM Value Set Addendum Available

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors

Upcoming Events

- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28
- IMPACT Act and Improving Care Coordination: Special Open Door Forum — September 28
- SNF QRP: Claims-Based Measures Confidential Feedback Report Webinar — September 28
- Home Health Agencies: Quality of Patient Care Star Rating Algorithm Call — October 10
- 2016 Annual QRURs Webcast — October 19

Medicare Learning Network Publications & Multimedia

- IMPACT Act Call: Audio Recording and Transcript — new
- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters® article — updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters® article — updated
- Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims MLN Matters® article — updated
- Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims MLN Matters® article — updated
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters® article — revised
- Global Surgery Fact Sheet — revised

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MLN Connects® Special Edition – JN providers

Monday, September 11, 2017

In this edition:

Hurricane Irma and Medicare disaster related United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida claims *MLN Matters*® article – new

The President declared a state of emergency for United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida claims and the HHS Secretary declared a Public Health Emergency which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An *MLN Matters*® special edition article on *Hurricane Irma and Medicare disaster related U.S Virgin Islands, Puerto Rico, and Florida claims* is available. Learn about blanket waivers CMS issued for the impacted counties and geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

Check the *Hurricanes* webpage for current information on temporary emergency policies and waivers.

View this edition as a PDF

MLN Connects® – Special Edition – JM providers

Monday, September 11, 2017

In this edition:

Hurricane Irma and Medicare disaster related South Carolina and Georgia claims *MLN Matters*® article — New

The President declared a state of emergency for the states of South Carolina and Georgia and the HHS Secretary declared a Public Health Emergency which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An *MLN Matters*® special edition article on *Hurricane Irma and Medicare disaster related South Carolina and Georgia claims* is available. Learn about blanket waivers CMS issued for the impacted counties and geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

Check the *Hurricanes* webpage for current information on temporary emergency policies and waivers.

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MLN Connects® Special Edition – September 21

Thursday, September 21, 2017

In this edition:

Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims *MLN Matters*® article — new

The President declared a state of emergency for the United States Virgin Islands and the Commonwealth of Puerto Rico and the HHS Secretary declared a Public Health Emergency which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An *MLN Matters*® special edition article on *Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims* is available. Learn about blanket waivers CMS issued for the impacted geographical areas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency.

Check the *Hurricanes* webpage for current information on temporary emergency policies and waivers.

MLN Connects® Special Edition – August 31

Thursday, August 31, 2017

In this edition:

- CMS helping Texas and Louisiana with Hurricane Harvey recovery
- Hurricane Harvey and Medicare disaster related Texas claims *MLN Matters*® article – new
- Tropical storm Harvey and Medicare disaster related Louisiana claims *MLN Matters*® article – new

CMS helping Texas and Louisiana with Hurricane Harvey recovery

On August 30, 2017, the Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma announced the efforts that are underway to support Texas and Louisiana in response to Hurricane Harvey. Earlier this week, Health and Human Services Secretary Tom Price, M.D., declared public health emergencies in both states. Actions include temporarily waiving or modifying certain Medicare, Medicaid and Children's Health Insurance Program (CHIP) requirements to provide immediate relief to those affected by the hurricane and resulting floods.

"In light of the natural disaster still unfolding in Texas and Louisiana, CMS is committed to acting as quickly and effectively as possible so the States can continue to ensure the vital health care needs of our most vulnerable beneficiaries are not interrupted," said CMS Administrator Seema Verma. "CMS is in constant communication with officials in Texas and Louisiana to be sure we are doing all we can to support those in the path of this historic and devastating storm."

See **HARVEY**, next page

HARVEY

previous page

CMS and the U.S. Department of Health and Human Services (HHS) are working in close coordination with the Kidney Community Emergency Response (KCER) Network and the states of Texas and Louisiana to ensure that beneficiaries have access to facilities to provide their treatments. As the CMS response continues, other efforts include, supporting Texas and Louisiana in arranging special purpose renal dialysis facilities, transporting patients to facilities and arranging for new facilities to open in order to serve beneficiaries without interruption. In Texas, CMS is coordinating with the workforce on the ground that cares for renal patients to ensure there are enough facilities to serve beneficiaries in need of dialysis. The agency is accepting requests from end stage renal disease suppliers to become a temporary special purpose renal dialysis facility (SPRDF).

Since the public health emergencies were declared, CMS has offered immediate administrative relief actions to Texas and Louisiana including issuing several general waivers of certain requirements for specific types of providers in impacted counties and geographical areas. These waivers work to prevent gaps in access to care for beneficiaries.

- Skilled nursing facilities (SNF): CMS waives requirements for a three-day prior hospitalization before admission in order to receive Medicare SNF services and provides temporary emergency coverage of services in SNFs without a qualifying hospital stay for people who are evacuated, transferred, or otherwise dislocated due to Hurricane Harvey. Certain people with Medicare benefits who recently exhausted their SNF benefits are authorized for renewed coverage without first having to start a new benefit period.
- Home health agencies: This CMS waiver provides relief to home health agencies on the timeframes related to completion of OASIS (assessment data) Transmission.
- Critical access hospitals (CAH): CMS waives the requirements limiting the number of patient beds to 25, and allows for length of stays beyond the capped 96-hour time period.

With the public health emergency in effect, CMS can also waive or modify certain Medicare provisions for providers, including certain deadlines, conditions of participation and certification requirements. Providers can now submit waiver requests to the state survey agency or the CMS regional office and they will be evaluated to ensure that they meet the requirements set out under the law. To help clarify billing instructions, CMS has issued technical direction to the Medicare administrative contractors regarding the waivers and has reminded area Medicare Advantage plans regarding their responsibilities to relax certain requirements during a disaster or emergency.

CMS will continue to work with the states of Texas and Louisiana. The agency continues to update our emergency page (*www.cms.gov/emergency*) with important information for state and local officials, providers, healthcare facilities and the public.

To read previous updates regarding HHS activities related to Hurricane Harvey, please visit *https://www.hhs.gov/about/news*.

To learn more about HHS resources related to Hurricane Harvey, please visit *https://www.hhs.gov/hurricane-harvey*.

Hurricane Harvey and Medicare disaster related Texas claims *MLN Matters*® article – new

The President declared a state of emergency for Texas and the HHS Secretary declared a public health emergency for Texas which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An *MLN Matters*® special edition article on *Hurricane Harvey and Medicare disaster related Texas claims* is available. Learn about blanket waivers CMS issued in the impacted counties and geographical areas in Texas. These waivers will prevent gaps in coverage for beneficiaries impacted by the emergency.

Check the Hurricanes webpage for current information on temporary emergency policies and waivers. Additional waiver requests are being reviewed, and the webpage will be updated as decisions are made.

Tropical storm Harvey and Medicare disaster related Louisiana claims *MLN Matters*® article – new

The President declared a state of emergency for Louisiana and the HHS Secretary declared a Public Health Emergency for Louisiana which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An *MLN Matters*® special edition article on *Tropical storm Harvey and Medicare disaster related Louisiana claims* is available. Learn about blanket waivers CMS issued in the impacted counties and geographical areas in Louisiana. These waivers will prevent gaps in coverage for beneficiaries impacted by the emergency.

Check the *Hurricanes* webpage for current information on temporary emergency policies and waivers. Additional waiver requests are being reviewed, and the webpage will be updated as decisions are made.

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