Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

October 2017

In this issue

2018 annual update for the HPSA bonus payments

Provider type affected

This *MLN Matters*® article is intended for physicians submitting claims to Medicare administrative contractors (MACs) for services provided in health professional shortage areas (HPSAs) to Medicare beneficiaries.

Provider action needed

Change request (CR) 10317 alerts you that the Centers for Medicare & Medicaid Services (CMS) will make the annual HPSA bonus payment file for 2018 available to your MAC to use for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2018, through December 31, 2018. You should review the Physician Bonuses webpage at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/* each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

Background

Section 413(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. The HPSA ZIP code file is populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file shall be made available to your MAC in early December of each year. MACs will implement the HPSA ZIP code file and for claims with dates of service January 1 to December 31 of the following year,

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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

Mass adjustment of 2017-2018 influenza vaccine claims

Issue

Contractors are required to implement 2017-2018 influenza vaccine payment allowances no later than October 2. Once files are updated, reprocessing will occur for claims processed on or after August 1.

Resolution

Medicare administrative contractors (MACs) will initiate a mass adjustment process to reprocess claims by November 1. These instructions supersede instructions given in *MLN Matters*® *MM10224* regarding claim adjustments.

Status/date resolved

Open

Provider action

There is no action required by the provider.

Current processing issues

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

Outpatient claims: Correcting deductible and coinsurance for code G0473

Issue

Currently, deductible and coinsurance is being applied incorrectly for HCPCS G0473 (face-to-face behavioral counseling for obesity, 15 minutes). The following claims are affected:

HCPCS code = G0473

Receipt date = on or after October 1, 2017, and prior the January 2018 IOCE update release

Types of bill = 13x

Resolution

The system will be updated in January 2018; Medicare administrative contractors will mass adjust these claims within 60 calendar days of the update.

Status/date resolved

Open

Provider action

There is no action required by the provider.

Current processing issues

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

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make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

Additional information

The official instruction, CR 10317, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3870CP.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 29, 2017	Initial article released.

MLN Matters® Number: MM10317
Related CR Release Date: September 29, 2017
Related CR Transmittal Number: R3870CP
Related Change Request (CR) Number: 10317
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

General Information

Changes ahead for HETS application: HCPCS code changes and new preventive codes

The Centers for Medicare & Medicaid Services (CMS) has released several changes to the Health Insurance Portability and Accountability Act (HIPAA) eligibility transaction system (HETS) application, which will go into effect November 4, 2017. The changes will impact providers who use First Coast Service Options' (First Coast's) Secure Provider Online Tool (SPOT) to access eligibility data through HETS.

This article announces the first two of the 10 upcoming changes. It is the first in a series of articles – one will be published each week CMS has released several changes to the HETS application, which will go into effect November 4, 2017. The changes will impact providers who use First Coast's SPOT to access eligibility data through HETS.

This article announces the first two of the 10 upcoming changes. It is the first in a series of articles – one will be published each week – explaining the changes before the November 4, 2017, implementation date.

Preventive HCPCS code changes

HETS 270/271 will return only preventive HCPCS code information for the current date, instead of the current calendar year.

Newly supported preventive HCPCS codes

HETS 270/271 will begin supporting the following HCPCS codes:

- **81528** – Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
- **G0297** – Low dose CT scan (LDCT) for lung cancer screening
- **G0442** – Annual alcohol misuse screening, 15 minutes
- **G0443** – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- **G0472** – Hepatitis C antibody screening, for individual at high risk and other covered indications
- **G0473** – Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes
- **G0475** – HIV antigen/antibody, combination assay, screening explaining the changes before the November 4, 2017, implementation date.

Quarterly provider update

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

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

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

Hurricane Nate and Medicare disaster-related Alabama, Florida, Louisiana, and Mississippi 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 Alabama, Florida, Louisiana, and Mississippi, who were affected by Hurricane Nate.

Provider action needed

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Nate, an emergency exists in Alabama, Florida, Louisiana, and Mississippi.

On October 8, 2017, Acting Secretary Wright of the Department of Health & Human Services declared that a public health emergency exists in the states of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On October 10, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the States of Louisiana retroactive to October 5, 2017; Mississippi, and Alabama retroactive to October 6, 2017; and Florida retroactive to October 7, 2017, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Nate in 2017. 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 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:

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 within Alabama, Florida, Louisiana and Mississippi 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.

The most current information can be found at *https://www.cms.gov/emergency* posted in the downloads section at the bottom of the Emergency Response and Recovery webpage.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the Alabama, Florida, Louisiana, and Mississippi. 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 Alabama, Florida, Louisiana and Mississippi.
- 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 for Alabama, Florida, Louisiana, and Mississippi.

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 for Alabama, Florida, Louisiana, and Mississippi

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following blanket waivers in the affected areas of Alabama, Florida, Louisiana and Mississippi. 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 Nate in Alabama,

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- Florida, Louisiana, and Mississippi 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 Nate, 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. (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.)

Durable medical equipment

- As a result of Hurricane Nate, 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.
- As a result of Hurricane Nate, CMS is temporarily extending the 10-business day deadline to provide notification of any subcontracting arrangements. During the temporary extension period, affected contract suppliers will have 30-business days to provide notice to the competitive bidding implementation contractor of any subcontracting arrangements. CMS will notify DMEPOS competitive bidding contract suppliers via e-mail when this temporary extension expires. All other competitive bidding program requirements remain in force. **Note**: CMS will provide notice of any changes to reporting timeframes for future events.
- For more information refer to the *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-pdf*.

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.

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 Nate, 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 Nate, 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.

These temporary emergency policies would apply to the

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

***Note**: The article was updated October 2, 2017, to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same. This information was previously published in the September 2017 Medicare A Connection, pages 10-12.*

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 action needed

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.

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timeframes specified in the waiver(s) issued under Section 1135 of the Act in connection with the effect of Hurricane Nate in Alabama, Florida, Louisiana, and Mississippi. More information is available in the 1135 waiver letter, which is posted in the *Downloads* section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*.

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.

Document history

Date of change	Description
October 11, 2017	Initial article released.

MLN Matters® Number: SE17034
Article Release Date: October 11, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
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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 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 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.)

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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.

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.

Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria – This information added October 2, 2017.

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, renal dialysis facilities, and ambulatory surgical centers located in areas affected by Hurricane Maria due to the devastating impact of the storm. These providers will be granted exceptions without having to submit an extraordinary circumstances exceptions (ECE) request if they are located in one of the 78 Puerto Rico municipios or one of the three U.S. Virgin Islands county-equivalents, all of which have been designated by the *Federal Emergency Management Agency (FEMA)* as a major disaster municipio or county-equivalent.

The scope and duration of the exception under each Medicare quality reporting program is described in the memorandum that CMS posted *September 25, 2017*, however, all of the exceptions are being granted to assist these providers while they direct their resources toward caring for its patients and repairing structural damages to facilities.

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*.

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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, Maria, or Nate, 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 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)

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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
October 2, 2017	The article was updated to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same.

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

MLN Matters® Number: SE17028 *Revised*
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Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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Providers affected by Hurricanes Harvey, Irma, and Maria

In response to the devastation of Hurricanes Harvey, Irma, and Maria, 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 26, 2017. (**Note**: Due to Hurricane Maria, this date has been extended for Puerto Rico and the U.S. Virgin Islands to October 30, 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 claim processing. You may follow your normal process for responding. This information may be found within your ADR letter.

Accepting payment from patients with a Medicare set-aside arrangement

***Note**: This article was rescinded October 3, 2017. This information was previously published in the September 2017 Medicare A Connection, pages 21-22.*

Document history

Date of change	Description
September 19, 2017	Initial article released.
October 3, 2017	Article rescinded

MLN Matters® Number: SE17019 *Rescinded*
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

Prohibition on billing dually eligible individuals enrolled in the QMB program

***Note**: This article was revised October 18, 2017, to indicate that the provider remittance advice and the Medicare summary notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. This information was previously published in the October 2017 Medicare A Connection, pages 23-25.*

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) (effective November 4, 2017) and the provider remittance advice (RA) (effective October 2, 2017), 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)

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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.
2. 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.
3. 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

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- 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.

1. 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.
2. 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 XX)

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
October 18, 2017	The article was revised to indicate that the provider remittance advice and the Medicare summary notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.
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.
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.

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2018 Medicare physician fee schedule payment rates and participation program

The annual physician and supplier participation period begins January 1 of each year, and runs through December 31. The annual participation enrollment is scheduled to begin mid-November of each year. (**Note**: The dates listed for release of the participation enrollment/ fee disclosure material are subject to publication of the annual final rule.)

The 2018 Medicare physician fee schedule (MPFS) payment rates will be posted to First Coast Service Options' Medicare Provider website after publication of the MPFS final rule in the *Federal Register*. This publication usually occurs in mid-November.

Source: Publication 100-04, Chapter 1, Section 30.3.12.1 (B2)

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

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

Release Date of Revised Article: October 17, 2017
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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*.

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.

New LCD

Wound care – new Part A and Part B LCD

LCD ID number: L37166 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for wound care was developed based on data analysis, which identified an increase in utilization of wound care procedures. Furthermore, the existing wound debridement services LCD (L33566) was incorporated when creating this new LCD, which will be retired when the new LCD becomes effective.

Effective date

This LCD is effective for services rendered **on or after December 7, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Revisions to LCD

Infliximab (Remicade™) – revision to the Part A and B LCD

LCD ID number: L33704 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on CR 10230 (October 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.3), CR 10234 (Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2017 Update), CR 10236 (October 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)), and CR 10259 (October 2017 Update of the Ambulatory Surgical Center (ASC) Payment System), the "CPT®/HCPCS codes" section of the local coverage determination (LCD) for infliximab (Remicade™) was revised to add modifier ZC (Merck/Samsung Bioepis) to the asterisk explanation for HCPCS code Q5102.

Effective date

This LCD revision for CR 10234 is effective for claims processed **on or after October 01, 2017**, for services rendered **on or after July 24, 2017.** This LCD revision for CR 10230, CR 10236, and CR 10259 is effective for claims processed **on or after October 01, 2017**, for services rendered **on or after July 01, 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*.

Psychological and neuropsychological tests – revision to the Part A and B LCD

LCD ID number: L34520 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request asking for additional diagnosis codes for Parkinson's disease and epilepsy, the local coverage determination (LCD) for psychological and neuropsychological tests was revised. Diagnosis codes G20, G40.001 - G40.319, G40.A01 - G40.B19, and G40.401 - G40.919 were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (CPT®) codes 96101, 96102, 96103, 96118, 96119, 96120, and Healthcare Common Procedure Coding System (HCPCS) code G0451.

Effective date

This LCD revision is effective for services rendered **on or after October 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*.

Updates to Medicare's cost report worksheet S-10 to capture uncompensated care data

Provider type affected

This *MLN Matters*® special edition article is intended for all 1886(d) hospitals, including 1886(d) Puerto Rico hospitals, eligible to receive uncompensated care payments.

What you need to know

This article is intended to provide additional guidance to 1886(d) hospitals by summarizing revisions and clarifications to the instructions for the Worksheet S-10 of the Medicare cost report. The worksheet S-10 data is used in the computation of factor 3 in the calculation of the uncompensated care payment for 1886(d) hospitals under the Social Security Act (SSA) eligible to receive such payments. The revisions and clarifications to the worksheet S-10 are provided to ensure appropriate reporting of uncompensated care costs and to achieve proper Medicare reimbursement. Examples are also provided in this article as additional guidance.

The Centers for Medicare & Medicaid Services (CMS) provided an extension to allow all inpatient prospective payment systems (IPPS) hospitals to submit an amended cost report with revised worksheet S-10 data for fiscal year (FY) 14 and FY 15 by October 31, 2017. The resubmission of data is not required; providers may choose to resubmit if they have additional data for lines 20, 22, 25, and 26.

Background

Section 1886(r) of the Act, as added by Section 3133 of the Affordable Care Act, requires that, for FY 2014 and each subsequent fiscal year, subsection (d) hospitals that would otherwise have received a disproportionate share hospital (DSH) payment made under Section 1886(d)(5)(F) of the Act will receive two separate payments, a DSH payment and a payment for the hospital's proportion of uncompensated care.

In the 2018 Medicare IPPS final rule (82 Fed. Reg. 37990, August 14, 2017), CMS indicated that it would begin to incorporate data from worksheet S-10 in the computation of factor 3 for the calculation of hospitals' share of uncompensated care payments for fiscal year 2018. As part of CMS' continued desire to work with its stakeholders regarding the reporting of uncompensated care and to achieve greater clarity of the data needed to compute factor 3, CMS has clarified the instructions and line item descriptions on the worksheet S-10.

In transmittal 10, CMS clarified that hospitals may include discounts given to uninsured patients who meet the hospital's charity care criteria. In transmittal 11, CMS further clarified that full or partial discounts given to uninsured patients who meet the hospital's charity care policy or financial assistance policy/uninsured discount policy (hereinafter referred to as Financial Assistance Policy or FAP) may be included on line 20, column 1 of the worksheet S-10. These clarifications apply to cost reporting periods beginning on or after October 1, 2013.

CMS also modified the application of the cost-to-charge-ratio (CCR). The CCR will not be applied to the deductible and coinsurance amounts for insured patients approved for charity care and non-reimbursed Medicare bad debt. The CCR will be applied to uninsured patients approved for charity care or an uninsured discount, non-Medicare bad debt, and charges for non-covered days exceeding a length of stay limit imposed on patients covered by Medicaid or other indigent care programs.

Summary of modifications to the worksheet S-10 and examples

The following were implemented for worksheet S-10: 1) a revision to the instructions for electronic health records (EHR) incentive payments to apply to subsection (d) Puerto Rico hospitals for cost reporting periods beginning on or after October 1, 2016; and effective for cost-reporting periods beginning on or after October 1, 2013: 2) a clarification of the definition of charity care that includes the addition of uninsured discounts reported on line 20; 3) a clarification that Medicare and non-Medicare hospital bad debt reported on line 26 must be net of recoveries; 4) the addition of line 27.01, Medicare allowable bad debts for the hospital, that will be used to compute the non-Medicare bad debt separately from the non-reimbursed Medicare bad debt; 5) modifications to the calculation of costs for both insured charity care charges not subject to the CCR, and insured non-covered days beyond a length-of-stay limit subject to the CCR; and, 6) modifications to the calculation of non-Medicare bad debt subject to the CCR and non-reimbursed Medicare bad debt (deductible and coinsurance) not subject to the CCR. The modifications to the calculations will be applied to all cost reports, however providers will not be required to amend their cost report in order to benefit from these modifications.

Examples for the Worksheet S-10, Uncompensated and Indigent Care Data

For examples 1 through 3 only, assume the following facts: A hospital has a charity care policy which determines charity care on a "sliding scale" basis and may forgive anywhere from 25 to 100 percent of the patient's liability. An insured patient owes the hospital $100.00 for a deductible on an allowable hospital service. The insured patient applies for charity care and the hospital determines that he qualifies for charity care at 25 percent. The cost reporting period is on or after October 1, 2016.

Example 1: Unpaid insured patient's liability

The hospital deems $25.00 of the patient's $100.00 liability as charity care and records this $25.00 on line 20, column 2. The remaining $75.00 is a patient liability. The $75.00 remaining patient liability may subsequently be determined

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by the hospital to be classified as charity care or a hospital bad debt, but not both. (It is generally assumed that insured persons are not eligible for charity care, however an insured person can qualify for charity care for the portion of the charges that represents the patient liability pursuant to the hospital's charity care policy).

Example 2: Partial payment of insured patient's liability

The hospital deems $25.00 of the patient's $100.00 liability as charity care and records this $25.00 on line 20, column 2. The patient pays $35.00 of the $75.00 patient liability. The hospital can determine the remaining $40.00 patient liability to qualify as charity care or a bad debt, but not both. If the $40.00 is determined to be charity care, it is recorded on line 20, column 2. If it is determined to be a bad debt, it is recorded on line 26 as a hospital bad debt.

Example 3: Partial payment of insured patient's liability, a Medicare beneficiary

The hospital deems $25.00 of the patient's $100.00 liability as charity care and records this $25.00 on line 20, column 2. The hospital makes reasonable collection efforts to collect the remaining $75.00 patient liability. The patient pays $35.00 of the $75.00 patient liability. The hospital determines the unpaid $40.00 patient liability to be a Medicare bad debt. The $40.00 unpaid patient liability would be recorded on line 26 as a hospital bad debt and be reflected on line 27.01 as the Medicare allowable bad debt. The Medicare reimbursable bad debt, $26.00, would be reflected on line 27 (assuming a 65 percent bad debt limitation pursuant to 42 CFR 413.89(h)).

Example 4: Uninsured patient, sliding scale charity care, partial payment of patient liability with remaining amount of patient liability unpaid, cost-reporting periods beginning on or after October 1, 2016

A hospital has a charity care policy which determines charity care on a "sliding scale" basis and may forgive anywhere from 25 to 100 percent of the patient's liability. An uninsured patient owes the hospital $1,000.00 for an allowable hospital service. The patient applies for charity care, and the hospital determines that the uninsured patient qualifies for charity care at 60 percent. The hospital records the $600.00 charity care amount on line 20, column 1. The remaining $400.00 is the patient's liability. The uninsured patient pays $100.00 toward his liability. If the patient does not pay the remaining $300.00 and the hospital determines the unpaid patient liability to be a bad debt, the hospital would record the $300.00 on line 26 as a hospital bad debt. The $100.00 payment made by the patient does not get recorded anywhere on the worksheet S-10 because it was not a payment toward the amount deemed charity care; it was a payment toward the non-charity care patient liability.

Example 5: Uninsured patient, sliding scale charity care, partial payment of patient liability with remaining amount of patient liability unpaid, cost reporting periods beginning prior to October 1, 2016

A hospital has a charity care policy which determines charity care on a "sliding scale" basis and may forgive anywhere from 25 to 100 percent of the patient's liability. An uninsured patient owes the hospital $1,000.00 for an allowable hospital service. The patient applies for charity care, and the hospital determines that the uninsured patient qualifies for charity care at 60 percent. The hospital records the entire $1,000.00 charge as charity care on line 20, column 1. The remaining $400.00 is the patient's liability and must be recorded on line 22 as this is a patient liability for which the hospital expects to receive payment. The uninsured patient pays $100.00 toward his $400.00 liability. The $100.00 patient payment does not get recorded on worksheet S-10 because the $400.00 full patient liability was already recorded as an expected payment on line 22. If the $300.00 balance remains unpaid and the hospital determines it to be a bad debt, it can be recorded as a hospital bad debt on line 26.

Example 6: Uninsured patient, sliding scale charity care, partial payment of patient liability with remaining amount of patient liability unpaid, cost reporting periods beginning prior to October 1, 2016, with patient liability payment made in a cost reporting period that began on or after October 1, 2016

A hospital has a charity care policy which determines charity care on a "sliding scale" basis and may forgive anywhere from 25 to 100 percent of the patient's liability. In a cost reporting period that began prior to October 1, 2016, an uninsured patient owes the hospital $1,000.00 for an allowable hospital service. The patient applies for charity care, and the hospital determines that the uninsured patient qualifies for charity care at 60 percent. The hospital records the entire $1,000.00 charge as charity care on line 20, column 1. The remaining $400.00 is the patient's liability, however the provider did not record the payment/expected payment on line 22 as required. Several months later, in a cost reporting period that began on or after October 1, 2016, the uninsured patient made a payment of $100.00. This $100.00 payment must be recorded on line 22 as a reduction of an amount previously deemed charity care.

Example 7: Uninsured patient qualifies to receive an uninsured patient discount pursuant to hospital's FAP, cost-reporting periods beginning on or after October 1, 2016

An uninsured patient owes the hospital $100.00 for an allowable hospital service. The uninsured patient does not qualify for charity care. The hospital has a FAP which automatically gives a 30% discount to all uninsured patients who meet the hospital's FAP. The uninsured

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patient meets the hospital's FAP and the hospital writes off $30.00 as an uninsured discount on line 20, column 1. The remaining $70.00 is a patient liability. If the $70.00 patient liability remains uncollected and the hospital determines it to be a bad debt, it is recorded on line 26 as a hospital bad debt. (If the cost reporting period began prior to October 1, 2016 using the same scenario above, the full charges of $100.00 would be written off on line 20, column 1. The hospital would record $70.00 on line 22 as an expected payment. If the $70.00 patient liability remains uncollected and the hospital determines it to be a bad debt, it is recorded on line 26 as a hospital bad debt).

Example 8: Calculating the cost of insured patients approved for charity care when line 20, column 2 includes charges for patient days beyond the length-of-stay limit for Medicaid or another indigent care program

Charges for patient days beyond the length of the stay limit are recorded on line 20, column 2. At the end of the fiscal year when preparing its cost report, a hospital, whose CCR is 0.31, has accrued charges for patient days beyond the length-of-stay limit imposed on patients covered by Medicaid in the amount of $10,000 and is reported on line 20, column 2. The hospital also has $550,000 in charity care charges for deductible and co-insurance amounts on line 20, column 2. The net amount reported on line 20, column 2 is $560,000, ($550,000 + $10,000). The hospital answers "yes" to line 24 and reports $10,000 on line 25. When calculating the cost of insured patients approved for charity care on line 21, column 2, the hospital must multiply line 25, $10,000, by the CCR, 0.31 on line 1 and add it to the result of line 20, column 2, $560,000 minus line 25, $10,000.

($560,000 - $10,000) + ($10,000 x 0.31)

$550,000 + $3,100

= $553,100 line 21, column 2

Additional information

Additional information regarding uncompensated care

and the Worksheet S-10 can be found in the 2018 IPPS final rule at 82 Fed. Reg. 37990 (August 14, 2017).
The following resources are available to find additional information regarding instructions to the worksheet S-10 for uncompensated care, see *Provider Reimbursement Manual* *transmittal 11* containing updates to CMS Pub. 15-2, Chapter 40, Section 4012.

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 29, 2017	Initial article released.

MLN Matters® Number: SE17031
Article Release Date: September 29, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Submit cost report information using SPOT

Part A provider groups including hospitals, nursing homes, skilled nursing homes, end-stage renal disease treatment facilities, federally-qualified health centers and rural health centers may file annual cost report information through First Coast's Secure Online Provider Tool (SPOT) using the *Secure Messaging feature*.

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

***Note**: This article was re-issued October 3, 2017, to confirm that its content remains valid even though special edition article SE1607 was rescinded. This information was previously published in the May 2017 Medicare A Connection, page 17.*

Provider types affected

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

What you need to know

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

Background

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

Additional information

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

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

Document history

Date	Description
October 3, 2017	Article re-issued to confirm that its content remains valid even though special edition article SE1607 was rescinded.
April 28, 2017	Initial article released.

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

Decommissioning of FPS 26 reject for new vs established patient

A system edit has been retired that was rejecting some "new patient" claims from critical access hospitals (CAHs), when a patient was established with the hospital or hospital system within a three-year period. The CAHs were then resubmitting the claims and receiving payment at the "established" patient rate.

If impacted, the CAH will need to cancel the established patient claims and resubmit the claims with the "new patient" codes. If you have questions, please contact your Medicare administrative contractor provider contact center:

PR: (877) 908-8433

FL/USVI: (888) 664-4112

Fiscal Year 2018 inpatient prospective payment system (PPS) and long-term care hospital 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 CR 10273 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-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html*
- FY 2018 Final Rule Data Files webpage: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Data-Files.html*
- MAC Implementation Files webpage: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-MAC-Implementation.html*

Alternatively, the files on the webpages listed above are also available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*. Click on the link on the left side of the screen titled *FY 2018 IPPS Final Rule Home Page* or the link titled *Acute Inpatient--Files for Download* (and select *Files for FY 2018 Final Rule and Correction Notice*).

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.

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Fiscal year 2018 inpatient and LTCH prospective payment system claims hold

Due to revised rates in the fiscal year (FY) 2018 inpatient prospective payment system (IPPS) and long-term care hospital (LTCH) PPS final rule correction notice, CMS-1677-CN, published September 29, 2017, the FY 2018 IPPS and LTCH PPS pricers will be installed into production October 23, 2017. As a result, all IPPS and LTCH PPS claims with discharge dates on or after October 1, 2017, through October 23, 2017, are being held by your Medicare administrative contractor (MAC) until the pricers are tested and installed. Since the required 14-day payment floor count begins the day a claim is received by the MAC, any clean claims held until October 23, 2017, will not be subject to another payment floor. Please contact your MAC with any questions:

PR: (877) 908-8433
FL/USVI: (888) 664-4112.

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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 with drug-eluting stent with MCC or 4+ arteries or stents and Percutaneous cardiovascular procedures with non-drug-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.
- 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; 04VC3EZ; 04VC4EZ; 04VD0EZ; 04VD3EZ or 04VD4EZ (CMS notes ICD-10-PCS procedure codes 04VC0FZ; 04VC3FZ; 04VC4FZ; 04VD0FZ; 04VD3FZ; and 04VD4FZ are no longer valid effective October 1, 2017)
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, 1x5A, T45.1x5D, or T45.1x5S in combination with (ICD-10-PCS

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procedure code W0DX82

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) d 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 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 crosswalking 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.

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

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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.

H. Multicampus 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. 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,

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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 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.

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 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specified fiscal year. 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.

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

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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 the aggregate amount available for uncompensated care payments 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 using three sets of data. The first two sets of data consist of Medicaid days and Medicare SSI days, while the third consists of hospital uncompensated care costs from worksheet S-10.

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.

For FY 2018, new hospitals with a CCN established after October 1, 2014 that are eligible for Medicare DSH will have their factor 3 calculated at cost report settlement using uncompensated care costs reported on line 30 of worksheet S-10 as the numerator and a denominator of $25,199,302,174. Factor 3 is then applied to the total uncompensated care payment amount finalized in the FY 2018 IPPS final rule to determine the total amount to be paid to the hospital. MACs can refer to the Medicare DSH supplemental data file on the CMS website to confirm whether a hospital should be treated as new.

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

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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 8 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 standard Federal payment rate cases. Accordingly, the FY 2018 fixed-loss amount of $27,381 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.

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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 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 fiscal year 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 LTCHPPS

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.

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/R3885CP.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/*.

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Calculating interim rates for graduate medical education payments to new teaching hospitals

Provider type affected

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

Provider action needed

Change request (CR) 10240 provides instructions to the MACS on calculating interim rates for graduate medical education (GME) payments to new teaching hospitals. Make sure your billing staffs are aware of this notification.

Background

Section 1886(h) of the Social Security Act (the Act), currently implemented in the regulations at *42 Code of Federal Regulation* (CFR) 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved GME programs. In general, Medicare direct GME payments are calculated by multiplying the hospital's updated per resident amount (PRA) by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (and at non-provider sites, when applicable), and the hospital's ratio of Medicare inpatient days to total inpatient days.

Section 1886(d)(5)(B) of the Act, as implemented at 42 CFR 412.105, provides for a payment adjustment known as the indirect medical education (IME) adjustment under the hospital Inpatient prospective payment system (IPPS) for hospitals that have residents in an approved GME program, in order to account for the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. The hospital's IME adjustment applied to the diagnosis-related group (DRG) payments is calculated based on the ratio of the hospital's number of FTE residents training in the inpatient and outpatient departments of the IPPS hospital (and at non-provider sites, when applicable), to the number of inpatient hospital beds. This ratio is referred to as the IME intern-and-resident-to-bed (IRB) ratio.

Under Section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for direct GME in its most recent cost reporting period ending on or before December 31, 1996. Under Section 1886(d)(5)(B)(v) of the Act, a similar limit based on the FTE count for IME during that cost reporting period is applied effective for discharges occurring on or after October 1, 1997. Dental and podiatric residents are not included in this statutory cap.

Section 1886(h)(4)(H)(i) of the Act requires the Secretary to establish rules for calculating the direct GME caps for new teaching hospitals that are training residents in new medical residency training programs established on or after January 1, 1995. Under section 1886(d)(5)(B)(viii) of the Act, such rules also apply to the establishment of a hospital's IME cap on the number of FTE residents training in new programs. The Centers for Medicare & Medicaid Services (CMS) implemented these statutory requirements in rules published in the following *Federal Registers* -- August 29, 1997 (62 FR 46002 through 46008), May 12, 1998 (63 FR 26323 through 26325 and 26327 through 26336), and August 27, 2009 (74 FR 43908 through 43919).

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Document history

Date of change	Description
October 18, 2017	This article was revised to reflect a revised CR 10273 issued October 17. The CR was revised to update the factor 3 denominator for hospitals treated as new, the fixed-loss amount for LTCH standard Federal payment rate cases, reference to the grouper software version, applicable tables and files available on the CMS website, and to clarify the list of ICD-10 codes eligible for the GORE IBE device system new technology add-on payment. In addition, updating the assignment of the wage index for Indian health service or tribal hospitals of the pricer in the attachment to the CR. The article was updated accordingly. All other information remains the same.
September 11, 2017	Initial article released.

MLN Matters® Number: MM10273
Related CR Release Date: October 17, 2017
Related CR Transmittal Number: R3885CP
Related Change Request (CR) Number: 10273
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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Current regulations on new program caps

Generally, under existing regulations at 42 CFR 413.79(e)(1) (for direct GME) and 42 CFR 412.105(f)(1)(vii) (for IME), if a hospital did not train any allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996, and it begins to participate in training residents in a new medical residency training program (allopathic or osteopathic) on or after January 1, 1995, the hospital's unweighted FTE resident cap (which would otherwise be zero) may be adjusted based on the sum of the product of the highest number of FTE residents in any program year during the fifth year of the first new program's existence at all of the hospitals to which the residents rotate, the minimum accredited length for each type of program, and the ratio of the number FTE residents in the new program that trained at the hospital over the entire five-year period to the total number of FTE residents in the program that trained at all hospitals over the entire five-year period. The number of FTE resident cap slots that a teaching hospital receives for each new program may not exceed the number of accredited slots that are available for each new program. See the August 31, 2012 *Federal Register* (77 FR 53416) for details on how the cap calculation is made. Similar regulations apply for IME at 42 CFR 412.105(f)(1)(vii). In the August 22, 2014, *Federal Register* (79 FR 50104 through 50111), CMS again revised the regulations at 42 CFR 413.79(e)(1) for direct GME and 42 CFR 412.105(f)(1)(v)(D) for IME, to state that if a hospital begins training residents in a new program on or after October 1, 2012, the hospital's FTE caps will take effect with the beginning of the hospital's cost reporting period that coincides with or follows the start of the sixth program year of the first new program started. Also, under 42 CFR 413.79(d)(5) for direct GME and 42 CFR 412.105(f)(1)(v) and 412.105(a)(1)(ii) for IME, FTE residents in new programs are exempt from the application of the 3-year rolling average and the IME intern-and-resident-to-bed (IRB) ratio cap. For programs started after October 1, 2012, these exemptions are applicable during the cost reporting periods prior to the beginning of the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, in which the FTE cap is established.

Establishment of a direct GME (DGME) per resident amount

Under Section 1886(h)(3) of the Act, and implemented at 42 CFR §413.77(e)(1), if a hospital did not previously have a per-resident amount (PRA) established, but begins training in a cost reporting period beginning on or after July 1, 1985, the MAC establishes a PRA effective with the hospital's first cost reporting period in which it participates in Medicare and has residents on duty during the first month of that cost-reporting period. Effective for cost-reporting periods beginning on or after October 1, 2006, if a hospital did not have residents on duty during the first month of that period, the MAC establishes a PRA using the information from the first cost-reporting period immediately

following the cost reporting period during which the hospital participates in Medicare and residents began training at the hospital.

As 42 CFR §413.77(e)(1) states, any GME costs incurred by the hospital in the cost-reporting period prior to the PRA-base period are reimbursed on a reasonable-cost basis. For example, a hospital with a January 1 to December 31 cost reporting period starts to train residents in an approved residency program for the first time July 1, 2017. The residents continue to train at the hospital in January 2018 and after. The hospital's PRA would be established from and effective for direct GME payment during the January 2018 through December 2018 cost report, and the hospital would be paid based on Medicare's share of the reasonable GME costs in the January 2017 through December 2017 cost report.

In order for a PRA to be established, the residents need not be in a newly approved residency program, nor must the hospital be the sponsor, nor incur costs. Rather, a hospital counts the respective share of the FTE resident that trains in its hospital, whether it employs the resident or not. (See the September 4, 1990, *Federal Register*, 55 FR 36064-5, which explains that regardless of who employs the resident, each hospital would count the proportion of FTE time spent at its facility, both for the direct GME PRA-base year, and in the payment years, while the hospital that incurs the costs of the resident in any year would claim those costs on its cost report). The MAC shall calculate and finalize the hospital's final PRA as part of the settlement of the base year cost report. See below for instructions for establishing an interim rate PRA for purposes of paying the hospital an interim direct GME payment amount from approximately the time it starts to train residents in an approved program.

Resources for determining weighted average PRA include: –67 FR 50067 through 50069 (August 1, 2002); Determining hospital cost per FTE -- 54 FR 40286 (September 29, 1989), 55 FR 36063 through 36065 (September 4, 1990), HCFA Memorandum, BPO-F12, November 8, 1990, Questions and Answers Pertaining to Graduate Medical Education.

When to establish interim rates for a new teaching hospital participating in a new program(s)

When a hospital that does not have FTE caps and/or a

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PRA approaches its MAC and requests in writing (email is sufficient) IME and DGME payments due to training residents for the first time in a new approved GME residency program, the MAC shall, in accordance with the regulations governing interim rate reviews at 42 CFR §412.116(c) and 42 CFR §413.60 and 42 CFR §413.64(a) through (e).

- Use the policy guidance in CR10240 to verify that the hospital does not already have a PRA and/or FTE resident caps established, and the hospital is actually training residents in a new approved program. (Refer to the August 27, 2009 FR, page 43908, to determine if an approved program meets the "new" criteria).
- Establish interim IME and DGME payment rates for the hospital at the earliest scheduled rate review *after* the hospital submits a written request for payment. MACs need not perform a special rate review exclusively for establishing interim IME and DGME rates; rather, MACs may choose to wait until the next regularly scheduled rate review following receipt of the written request from the hospital, and establish interim rates for IME and DGME payments at that time.

Alternatively, if the hospital is training residents for the first time but the residents are in an existing program, and the new teaching hospital has received IME and/or DGME cap slots from another hospital under a Medicare GME affiliation agreement (under 42 CFR 413.79(f)), if the hospital requests in writing (email is sufficient) IME and DGME payments, the MAC shall

- Establish interim IME and DGME rates for the hospital in accordance with the regulations governing interim rate reviews at 42 CFR 412.116(c) and 42 CFR 413.60 and 42 CFR 413.64(a) through (e).
- A hospital must provide the necessary documentation (discussed below) in order for the MAC to establish the interim rates.

Documentation required for calculating interim IME and DGME rates for a new teaching hospital

If a hospital requests in writing (email is sufficient) that a MAC establish interim IME and DGME rates due to training residents for the first time in either new or existing approved program(s), the MAC shall request the following documentation from the hospital:

For IME and DGME:

- Formal accreditation letter or proof of accreditation of the applicable program(s) by the relevant accrediting body (ACGME, ADA, CPME. Note –AOA accreditation was subsumed by the ACGME beginning in 2015).
- Number of accredited positions being trained in the program for the relevant cost reporting year for which interim rates are being established
- Rotation schedules, or similar documentation, indicating where the residents are training, from which to develop estimated FTE counts applicable to the requesting hospital. For IME, FTE residents training in locations specified in the regulations at 42 CFR §412.105(f)(1)(ii) (A)-(E) may be counted. For DGME, FTE residents training in accordance with the regulations at 42 CFR §413.78 may be counted. The MAC shall ensure that the number of FTE residents based on which the hospital is paid in a year does not exceed the number of accredited slots available to the hospital for the particular program year.
- If applicable, a copy of the Medicare GME Affiliation Agreement under 42 CFR §413.79(f).

For IME:

- Available bed count from the most recently submitted cost report, but modified if appropriate as part of the current interim rate review. Determine the available bed count in accordance with the instructions on the Medicare cost report, CMS Form 2552-10, Worksheet E, Part A, line 4.
- Timely submission of claims for receipt of IME payments on behalf of inpatient services provided to Medicare fee-for-service and Medicare advantage beneficiaries, in accordance with 42 CFR 424.30 and 424.44.

For DGME:

- Medicare utilization – determine the hospital's Medicare utilization rate (or ratio of Medicare inpatient days to total inpatient days) in accordance with the instructions on the Medicare cost report, CMS Form 2552-10, Worksheet E-4, lines 26, 27, and 28, columns 1 and 2 for Part A and Part C, using the hospital's most recently submitted cost report (but modified as appropriate as part of the current interim rate review).
- Timely submission of claims for receipt of IME payments on behalf of inpatient services provided to Medicare Fee for Service and Medicare Advantage beneficiaries, in accordance with 42 CFR 424.30 and 424.44.
- For the PRA, see below.

Calculating an interim rate PRA

Under 42 CFR §413.77(e)(1)(i) and (ii), a new PRA is equal to the *lower of* the hospital's actual cost per resident incurred in the base period, or the weighted mean average PRA of all of the other existing teaching hospitals located in the same core-based statistical area (CBSA) as the new teaching hospital. Under 42 CFR §413.77(e)(1)(iii), if under §413.77(e)(1)(ii)(A) or (B) there are less than 3 existing teaching hospitals with PRAs located in the same CBSA as the new teaching hospital with PRAs that can be used for the weighted average PRA calculation, the census region PRA is used (updated for inflation to the new teaching hospital's base year cost reporting period).

Since the hospital's actual cost per FTE resident information would not be available until the hospital files its base year cost report, and since determination of the weighted average PRA for the CBSA can be labor

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Quarterly HCPCS drug/biological code changes – October 2017 update

Provider type affected

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

What you need to know

The Healthcare Common Procedure Coding System (HCPCS) code set is updated on a quarterly basis. The October 2017 HCPCS file includes a new HCPCS modifier. Change request (CR) 10234 informs MACs about the new modifier, ZC, Merck/Samsung Bioepis. The ZC modifier will become effective for claims submitted beginning October 1, 2017, and applies retroactively to dates of service on or after July 24, 2017.

MACs shall add the following modifier to the required modifiers that must be used when HCPCS code Q5102 is billed on a claim:

- HCPCS modifier: ZC
- Short description: Merck/Samsung Bioepis
- Long description: Merck/Samsung Bioepis

A second biosimilar version of infliximab was marketed July 24, 2017, creating a situation where products from two manufacturers may appear on claims. To allow the identification of the manufacturer of the specific biosimilar biological product that was administered to a patient, either existing HCPCS modifier ZB, or new modifier ZC is required when HCPCS code Q5102 is billed on a claim that is submitted after October 1, 2017.

Additional information

The official instruction, CR 10234, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3850CP.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 26, 2017	Initial article released.

MLN Matters® Number: MM10234
Related CR Release Date: August 25, 2017
Related CR Transmittal Number: R3850CP
Related Change Request (CR) Number: 10234
Effective Date: July 24, 2017
Implementation Date: October 2, 2017

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intensive, the MAC shall use the latest available census region PRA issued by CMS for the census region in which the new teaching hospital is located, updated for inflation to the base period of the new teaching hospital, for the purpose of calculating and paying DGME interim rates. However, once the hospital submits its base year cost report, the MAC shall calculate and assign the appropriate PRA to the new teaching hospital (as part of the normal cost-report settlement process for the new teaching hospital). The MAC shall calculate the interim rate subsequently using the hospital's permanently-assigned PRA, updated with inflation.

Additional information

The official instruction, CR 10240, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1923OTN.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 26, 2017	Initial article released.

MLN Matters® Number: MM10240
Related CR Release Date: September 22, 2017
Related CR Transmittal Number: R1923OTN
Related Change Request (CR) Number: N/A
Effective Date: October 23, 2017
Implementation Date: October 23, 2017

January 2018 quarterly average sales price Medicare Part B drug pricing files

Provider type affected

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

What you need to know

Change request (CR) 10320 instructs MACs to download and implement the January 2018 and, if released, the revised October 2017, July 2017, April 2017, and January 2017, ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) Data Center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 2, 2018, with dates of service January 1, 2018, through March 31, 2018. Make sure your billing staffs are aware of these changes.

Background

The average sales price (ASP) methodology is based on quarterly data that manufacturers submit to the CMS. CMS supplies the MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the Internet Only Manual (IOM) which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

- **File**: January 2018 ASP and ASP NOC -- effective for dates of service: January 1 through March 31, 2018
- **File**: October 2017 ASP and ASP NOC – effective for dates of service: October 1 through December 31, 2017
- **File**: July 2017 ASP and ASP NOC – effective for dates of service: July 1 through September 30, 2017
- **File**: April 2017 ASP and ASP NOC – effective for dates of service: April 1 through June 30, 2017
- **File**: January 2017 ASP and ASP NOC – effective for dates of service: January 1 through March 31, 2017

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

Additional information

The official instruction, CR 10320, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3878CP.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
October 6, 2017	Initial article released.

MLN Matters® Number: MM10320
Related Change Request (CR) Number: 10320
Related CR Release Date: October 6, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3878CP
Implementation Date: January 2, 2018

Extensions for all inpatient prospective payment system (IPPS) hospitals

Fiscal year (FY) 2014 and 2015 S-10 revisions

The Centers for Medicare & Medicaid Services (CMS) issued an extension for inpatient prospective payment system (IPPS) hospitals, from September 30, 2017, until October 31, 2017, for all IPPS hospitals to resubmit certain worksheet S-10 data. As described in the FY 2018 IPPS/ long-term care hospital prospective payment system (LTCH PPS) final rule (82 FR 38208, August 14, 2017), the initial deadline had been September 30, 2017. For revisions to be considered, CMS modified the deadline such that amended FY 2014 and FY 2015 cost reports due to revised or initial submissions of worksheet S-10 must be received by on or before October 31, 2017.

Changes to the laboratory national coverage determination edit software for January 2018

Provider type affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (regional home health intermediaries (RHHIs) and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 10309 which informs MACs about the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. CR 10309 applies to Chapter 16, Section 120.2, Publication 100-04. Make sure that your billing staffs are aware of these changes.

See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 10309 announces the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12-190.34) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, Section 120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. CR 10309 communicates requirements to shared system maintainers (SSMs) and contractors, notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for January 2018. Please access the link below for the NCD spreadsheets included with CR 10309: *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR207300-January2018.zip*.

MACs will adjust claims brought to their attention, but will not search their files to retract payment for claims already paid or retroactively pay claims.

Additional information

The official instruction, CR 10309, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3872CP.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
October 12, 2017	Initial article released.

MLN Matters® Number: MM10309
Related CR Release Date: October 6, 2017
Related CR Transmittal Number: R3872CP
Related Change Request (CR) Number: CR10309
Effective Date: October 1, 2017
Implementation Date: January 2, 2018

Upcoming provider outreach and educational events

New Medicare cards are coming: Will you be ready?

Date: Tuesday, November 14
Time: 11:30 a.m.-12:30 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0387453.asp

Ask-the-contractor teleconference (ACT): MSP for institutional providers

Date: Wednesday, December 6
Time: 10:30 a.m.-noon
Type of Event: Webcast
https://medicare.fcso.com/Events/0388041.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 September 28, 2017

MLN Connects® for September 28, 2017

View this edition as a PDF

News & Announcements

- Medicare Clinical Laboratory Fee Schedule: Preliminary CY 2018 Payment Rates
- 2016 PQRS Feedback Reports and Annual QRURs Updates
- Quality Payment Program: New Resources Available
- Quality Payment Program: View Recordings of Recent Webinars
- MIPS Eligible Measure Applicability: New Resources Available
- National Cholesterol Education Month and World Heart Day

Provider Compliance

- Psychiatry and Psychotherapy CMS Provider Minute Video — Reminder

Claims, Pricers & Codes

- Clinicians: Medicare Part B Crossover Claims Issue Tied to Error Code H51082

Upcoming Events

- Home Health Agencies: Quality of Patient Care Star Rating Algorithm Call — October 10
- 2016 Annual QRURs Webcast — October 19

Medicare Learning Network Publications & Multimedia

- 2017-2018 Influenza Resources for Health Care Professionals *MLN Matters*® article — New
- Billing in Medicare Secondary Payer Liability Insurance Situations *MLN Matters*® article — New

- Accepting Payment from Patients with Set-Aside Arrangements *MLN Matters*® article — New
- Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy Using a Disposable Device *MLN Matters*® article — New
- Transition to New Medicare Numbers and Cards Fact Sheet — New
- Nursing Home Call: Audio Recording and Transcript — New
- SNF Consolidated Billing Web-Based Training Course — Reminder
- Remittance Advice Resources and FAQs Fact Sheet — Reminder
- Medicare Enrollment Guidelines for Ordering/Referring Providers Booklet — Reminder

MLN Connects® for October 5, 2017

MLN Connects® for October 5, 2017

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News & Announcements

- National Partnership to Improve Dementia Care Achieves Goals to Reduce Unnecessary Antipsychotic Medications in Nursing Homes
- 2018 eCQM Value Set Addendum Available
- 2018 eCQM Logic Flows Available
- Health Services Research Health Equity Issue: Submit Abstracts by November 1
- Extension of Medicare IVIG Demonstration through December 31, 2020
- October is National Breast Cancer Awareness Month

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities — Reminder

Claims, Pricers & Codes

- FY 2018 IPPS and LTCH PPS Claims Hold

Upcoming Events

- 2016 Annual QRURs Webcast — October 19
- Definition of a Hospital: Primarily Engaged Requirement Call — November 2

Medicare Learning Network Publications & Multimedia

- Medicare Basics: Parts A and B Appeals Overview Video — New
- Updates to Medicare's Cost Report Worksheet S-10 to Capture Uncompensated Care Data *MLN Matters®* article — New
- Qualified Medicare Beneficiary Program Call: Audio Recording and Transcript — New
- Hospice Quality Reporting Program Call: Audio Recording and Transcript — New
- Hurricane Maria and Medicare Disaster Related United States Virgin Islands and Commonwealth of Puerto Rico Claims *MLN Matters®* article — Updated
- Reading a Professional Remittance Advice Booklet — Reminder
- Reading an Institutional Remittance Advice Booklet — Reminder

MLN Connects® for October 12, 2017

MLN Connects® for October 12, 2017
View this edition as a PDF

News & Announcements

- New Medicare Card Web Updates
- 2018 Medicare EHR Incentive Program Payment Adjustment Fact Sheet for Hospitals
- Qualifying APM Participant Look-Up Tool
- Hospice Quality Reporting Program: New and Updated Resources
- SNF Quality Reporting Program: Quick Reference Guide
- Protect Your Patients from Influenza this Season

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Claims, Pricers & Codes

- Home Health Claims Will Be Returned When No OASIS Is Found

Upcoming Events

- 2016 Annual QRURs Webcast — October 19
- Definition of a Hospital: Primarily Engaged Requirement Call — November 2

Medicare Learning Network Publications & Multimedia

- PQRS Call: Audio Recording and Transcript — New

MLN Connects® for October 19, 2017

MLN Connects® for October 19, 2017

View this edition as a PDF

News & Announcements

- Preview Draft eCQM Specifications through November 13
- MIPS Virtual Group Election Period Ends December 1
- Quality Payment Program: New Resources
- SNF Quality Reporting Program Confidential Feedback Reports for Claims-Based Measures
- SNF Review and Correct Report Update
- Post-Acute Care Quality Reporting Programs FY 2018 APU: Successful Facilities
- New CMS Legionella Requirement for Hospitals, Critical Access Hospitals, and Nursing Homes

Provider Compliance

- Coudé Tip Catheters CMS Provider Minute Video – Reminder

Claims, Pricers & Codes

- October 2017 OPPS Pricer File
- Outpatient Claims: Correcting Deductible and Coinsurance for Code G0473

Upcoming Events

- Definition of a Hospital: Primarily Engaged Requirement Call – November 2
- New Medicare Card Project Special Open Door Forum – November 9
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call – November 16

Medicare Learning Network Publications & Multimedia

- Medicare FFS Response to the 2017 California Wildfires *MLN Matters®* article – New
- Hurricane Nate and Medicare Disaster Related Alabama, Florida, Louisiana and Mississippi Claims *MLN Matters®* article – New
- Medicare Quarterly Provider Compliance Newsletter Educational Tool – New
- Physician Compare Call: Audio Recording and Transcript — New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program *MLN Matters®* article – Revised
- Critical Access Hospital Booklet – Revised

Preventive Resources

2017-2018 influenza resources for health care professionals

Provider type affected

- All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

What you need to know

- Keep this special edition *MLN Matters®* article and refer to it throughout the 2017 - 2018 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot if you have vaccine available, even after the New Year.
- Remember to immunize yourself and your staff.

Background

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (*Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.*)

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare's coverage of the annual flu shot. As a reminder, please help prevent the spread of flu by immunizing yourself and your staff!

See **FLU**, next page

FLU

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Know what to do about the flu!

Payment rates for 2017-2018

Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and *Current Procedure Terminology* (*CPT*®) codes and payment rates for personal flu and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the average wholesale price (AWP), except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. 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 following Medicare Part B payment allowances for HCPCS and *CPT*® codes apply:

Codes, payment allowances, and effective dates for the 2017-18 flu season

CPT® or HCPCS code	Payment allowance	Effective date
90630	$20.343	8/1/2017-7/31/2018
90653	$50.217	8/1/2017-7/31/2018
90654		Pending 8/1/2017-7/31/2018
90655		Pending 8/1/2017-7/31/2018
90656	$19.247	8/1/2017-7/31/2018
90657		Pending 8/1/2017-7/31/2018
90661		Pending 8/1/2017-7/31/2018
90662	$49.025	8/1/2017-7/31/2018
90672		Pending 8/1/2017-7/31/2018
90673	$40.613	8/1/2017-7/31/2018
90674	$24.047	8/1/2017-7/31/2018
90682	$46.313	8/1/2017-7/31/2018 (New code)
90685	$21.198	8/1/2017-7/31/2018
90686	$19.032	8/1/2017-7/31/2018
90687	$9.403	8/1/2017-7/31/2018
90688	$17.835	8/1/2017-7/31/2018
90756*	$22.793	1/1/2018-7/31/2018
Q2039**	**See Note below**	8/1/2017-7/31/2018
Q2035	$17.685	8/1/2017-7/31/2018
Q2036		Pending 8/1/2017-7/31/2018
Q2037	$17.685	8/1/2017-7/31/2018
Q2038		Pending 8/1/2017-7/31/2018

**Until CPT code 90756 is implemented on 1/1/2018, Q2039 will be used for products described by the following language: influenza virus vaccine, quadrivalent (ccllV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use. The payment allowance for these products, effective for dates of service from 8/1/2017 to 12/31/2017, is $22.793.*

***Providers and MACs will use HCPCS Q2039 for dates of service from 8/1/201712/31/2017. HCPCS Q2039 (Flu vaccine adult – not otherwise classified). The payment allowance will be determined by the local claim processing contractor with effective dates of 8/1/2017-7/31/2018.*

Providers are encouraged to review *MLN Matters*® article *MM10224* for more information on 2017-2018 influenza vaccines pricing.

Also, updates to payment limits and effective dates, when necessary, will be posted at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-BDrugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*.

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/*.

Educational products for health care professionals

The *Medicare Learning Network*® (*MLN*®) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

1. *MLN*® influenza-related products for health care professionals

- **Medicare Part B Immunization Billing chart** – *https://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network- MLN/MLNProducts/downloads/qr_immun_bill.pdf*
- **Preventive Services chart** – *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html*
- **MLN Preventive Services Educational Products webpage** – *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/ProviderResources.html*

See **FLU**, next page

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2. Other CMS resources

- **Immunizations webpage** – *https://www.cms.gov/Medicare/Prevention/Immunizations/index.html*
- **Prevention General Information** – *https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*
- **CMS Frequently Asked Questions** – *http://questions.cms.gov/faq.php*
- **Medicare Benefit Policy Manual** - Chapter 15, Section 50.4.4.2 – Immunizations *https://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/downloads/bp102c15.pdf*
- ***Medicare Claims Processing Manual*** – Chapter 18, Preventive and Screening Services *https://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/downloads/clm104c18.pdf*

3. Other resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2016-2017 flu season:

- **Advisory Committee on Immunization Practices** – *https://www.cdc.gov/vaccines/acip/index.html*

Other sites with helpful information include:

- **Centers for Disease Control and Prevention** – *https://www.cdc.gov/flu*
- **Flu.gov** – *https://www.flu.gov*
- **Food and Drug Administration** – *https://www.fda.gov*
- **Immunization Action Coalition** – *https://www.immunize.org*
- **Indian Health Services** – *https://www.ihs.gov*
- **National Alliance for Hispanic Health** – *https://www.hispanichealth.org*
- **National Foundation For Infectious Diseases** – *https://www.nfid.org/influenza*
- **National Library of Medicine and NIH Medline Plus** – *https://www.nlm.nih.gov/medlineplus/immunization.html*

- **National Vaccine Program** – *https://www.hhs.gov/nvpo*
- **Office of Disease Prevention and Health Promotion** – *https://healthfinder.gov/FindServices/Organizations/Organization/HR2013/office-of-disease-prevention-and-health-promotion-us-department-of-health-and-human-services*
- **World Health Organization** – *https://www.who.int/en*

Document history

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

MLN Matters® Number: SE17026
Related Change Request (CR) Number: N/A
Article Release Date: September 21, 2017
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

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.*

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