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

In this issue

Ambulance inflation factor for 2018 and productivity adjustment

Provider type affected

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

Provider action needed

Change request (CR) 10323 furnishes the calendar year (CY) 2018 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. The AIF for CY 2018 is 1.1 percent. Make sure that your billing staffs are aware of this change.

Background

CR 10323 furnishes the CY 2018 AIF for determining the payment limit for ambulance services required by Section 1834(l)(3)(B)) of the Social Security Act (the Act) which is available at *https://www.ssa.gov/OP_Home/ssact/title18/1834.htm*.

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3)) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity (MFP) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The MFP for CY 2018 is 0.5 percent and the CPI-U for 2018 is 1.6 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction

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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.

Accepting payment from patients with a Medicare set-aside arrangement

***Note**: This article was reissued November 8 to clarify information. The title of the article was also changed to better reflect the information. This information was previously published in the October 2017 Medicare A Connection, page 11.*

Provider type affected

This *MLN Matters*® article is intended for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a Medicare set-aside arrangement (MSA).

What you need to know

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

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

Background

Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made, or can reasonably be expected to be made promptly. When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

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

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

- The treatment or prescription is related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing AND
- The treatment or prescription is something Medicare would cover.

The obligation to protect the Medicare trust funds exists regardless of whether or not there is a formal CMS approved MSA amount. A Medicare beneficiary may or may not have documentation they can provide the physician, provider, or supplier from Medicare approving a Medicare set-aside amount.

Provider action needed

Where a patient who is a Medicare beneficiary states that he/she is required to use funds from the settlement, judgment, award, or other payment to pay for the items or services related to what was claimed or which the settlement, judgment, award, or other payment, it is appropriate for you to document your records with that information and accept payment directly from the patient for such services.

Additional information

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

Document history

Date of change	Description
November 8, 2017	The article was reissued to clarify information in the initial release. The title of the article was also changed to better reflect the information.
October 3, 2017	Rescinded
September 19, 2017	Initial article released.

MLN Matters® Number: SE17019 *Reissued*
Article Release Date: November 8, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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

Note: *The article was revised November 16 to reflect a revised change request (CR) 9911 issued November 15. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. All other information remains the same.* *August 2017 Medicare A Connection, pages 7-8*.

Provider type affected

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

Provider action needed

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

Background

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

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by federal law, states can limit provider payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the *Provider Reimbursement Manual (PRM)*.

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

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

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

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

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

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

In addition, the MACs will include a claim adjustment reason code of 209 ("Per regulatory or other agreement.

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The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with group code OA (other adjustment)).

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

Additional information

The official instruction, CR 9911, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3920CP.pdf*.

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

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

Document history

Date of change	Description
November 16, 2017	The article was revised November 16 to reflect a revised change request (CR) 9911 issued November 15. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. All other information remains the same.
July 24, 2017	The article was revised to add links to related *MLN Matters*® articles. *SE1128* reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. *MM9817* states that CR 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing

Date of change	Description
June 29, 2017	The article was revised to reflect a revised CR 9911 issued June 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. Clarifications were also made to the second paragraph of the *Background* section.
May 1, 2017	The article was revised to reflect a revised CR 9911 issued April 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised.
February 3, 2017	Initial article released

MLN Matters® Number: MM9911 *Revised*
Related CR Release Date: November 15, 2017
Related CR Transmittal Number: R3920CP
Related Change Request (CR) Number: CR 9911
Effective Date: For claims processed on or after October 2, 2017
Implementation Date: October 2, 2017

Prohibition on billing dually eligible individuals enrolled in the QMB program

***Note**: The article was revised to show the HIPAA eligibility transaction system (HETS) qualified Medicare beneficiary (QMB) release will be in November 2017. Previously, the 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. All other information remains the same. This information was previously published in the October 2017 Medicare A Connection, pages 11-14*.

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' 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) 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

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

- Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.

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- Beginning in November 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, visit *https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html*.
- Original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions on the Medicare provider RA, which will contain new notifications and information about a patient's QMB status for Part A and B claims processed on or after October 2, 2017. Refer to *Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System* for more information about these improvements.
- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.

- Providers and suppliers may also verify patient's QMB status through state online Medicaid eligibility systems or by asking patients for other proof such as their Medicaid identification card or a copy of their Medicare summary notice, the quarterly summary of claims sent to original Medicare beneficiaries that reflects, among other things, the patients' QMB status for Part A and B claims processed on or after October 2, 2017. 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 individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.
- 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 8)

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
November 3, 2017	Article revised to show the HETS QMB release will be in November 2017. All other information remains the same.
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.

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Date of change	Description
August 23, 2017	The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.
May 12, 2017	This article was revised May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.
January 12, 2017	This article was revised to add a reference to *MLN Matters*® article MM9817, which instructs Medicare administrative contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.
February 4, 2016	The article was revised February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under *Important Clarifications Concerning QMB Balance Billing Law*.
February 1, 2016	The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table.
March 28, 2014	The article was revised to change the name of the coordination of benefits contractor (COBC) to BCRC.

MLN Matters® Number: SE1128 *Revised*
Related Change Request (CR) #: N/A
Release Date of Revised Article: November 3, 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*.

CWF provider queries to only accept national provider identifier as valid provider number

Note: *This article was revised November 13, 2017, to reflect a revised change request (CR) 10098 issued November 9. In the article, the CR release date, transmittal number, and web address of CR are revised. All other information remains the same. This information was previously published in the August 2017 Medicare A Connection, page 5.*

Provider type affected

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

Provider action needed

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

Background

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

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

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

Additional information

The official instruction, CR 10098, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1976OTN.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
November 13, 2017	Article revised to reflect a revised CR. In the article, the CR release date, transmittal number, and Web address of CR are revised. All other information remains the same.
July 28, 2017	Initial article released.

MLN Matters® Number: MM10098 *Revised*
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R1976OTN
Related Change Request (CR) Number: CR10098
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Medicare establishes two new MSP set-aside arrangements

Note: *This article was rescinded. This information was previously published in the June 2017 Medicare A Connection, pages 3-4.*

MLN Matters® Number: MM9893 *Rescinded*
Related Change Request (CR) #: CR 9893
Related CR Release Date: N/A
Effective Date: October 1, 2017
Related CR Transmittal #: N/A
Implementation Date: October 2, 2017

Amount in controversy updates for 2018

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides for annual reevaluation of the dollar amount in controversy (AIC) required for an administrative law judge (ALJ) hearing (third level review) and federal district court review (fifth level review).

For requests made on or after January 1, 2018:

- The amount that must remain in controversy for ALJ hearing requests will remain at $160.
- The amount that must remain in controversy for federal district court review is increased to $1,600.

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.

Retired LCDs

Creatine Kinase (CK), (CPK) – retired Part A and Part B LCD

LCD ID number: L34042 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the Creatine Kinase local coverage determination (LCD), it was determined that this LCD is no longer required and, therefore, is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after November 9, 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, *click here*.

Multiple Part A and Part B local coverage determinations (LCDs) being retired

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

- L34019 – Rho (D) Immune Globulin Intravenous
- L34015 – Mitomycin (Mutamycin, Mitomycin-C)

Effective date

The retirement of these LCDs is effective for services rendered **on or after November 9, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Revisions to LCD

Cardiology— non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET – revision to the Part A and B LCD

LCD ID number: L36209 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request, the cardiology – non-emergent outpatient testing: exercise stress test, stress echo, Myocardial Perfusion Imaging (MPI) Single Photon Emission Computed Tomography (SPECT), and cardiac Positron Emission Tomography (PET) local coverage determination (LCD) was revised. Language added to the National Coverage Determination (NCD) for PET for Perfusion of the Heart (220.6.1) indication when PET scan (whether at rest alone or rest with stress) is performed in place of, but not in addition to, SPECT was removed. In addition, italics were removed from language italicized in error.

Effective date

This LCD revision is effective for services rendered **on or after December 9, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Noncovered services – revision to the Part A and Part B LCD

LCD ID number: L33777 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the LCD for Noncovered services was revised to remove *Current Procedural Terminology* (CPT®) code 84145 [Procalcitonin (PCT)] under the "CPT®/ HCPCS Codes" section of the LCD under the subtitle "Procedures for Part A and Part B".

Effective date

The LCD revision is effective for services rendered **on or after November 13, 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, *click here*.

Upper eyelid and brow surgical procedures – revision to the Part A and Part B LCD

LCD ID number: L34028 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change requests (CRs) 9658, 9668, 10236 and 10259, the "CMS National Coverage Policy" section of the upper eyelid and brow surgical procedures local coverage determination (LCD) was updated. In addition, an associated coding article was developed to include clarifying language related to upper eyelid blepharoplasty and blepharoptosis repair from the above CRs.

Effective date

The LCD revision is effective for services rendered **on or after October 1, 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*.

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.

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

***Note**: This article was revised October 30, 2017, to reflect the revised change request (CR) 10240 issued October 27. The CR was re-issued to revise several policy statements and to address how to handle certain impacted claims. This information was previously published in the October 2017 Medicare A Connection, pages 29-32.*

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

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 nonprovider 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 nonteaching 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 nonprovider 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).

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

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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 (PRA)

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 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 on 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 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

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(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.
- 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 three 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 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.

The MAC shall update the IME field in its file and establish a direct GME pass-through payment to reflect the appropriate interim payments to the hospital. MACs may enter the IME intern and resident to bed (IRB) ratio effective with the date that the residents in the approved program began training at the hospital, and may either reprocess claims for any retroactive period, or may work with the hospital to hold claims until an IRB ratio is entered into its file, and then claims may be processed

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prospectively. Alternatively, MACs may enter a current or prospective effective date for the IRB ratio in its file and may manually compute and issue a lump sum interim payment for any retroactive period.

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/R1952OTN.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 30, 2017	Article revised to reflect a re-issued CR, which revised several policy statements and addressed how to handle certain impacted claims.
September 26, 2017	Initial article released.

MLN Matters® Number: MM10240 *Revised*
Related CR Release Date: October 27, 2017
Related CR Transmittal Number: R1952OTN
Related Change Request (CR) Number: N/A
Effective Date: October 23, 2017
Implementation Date: October 23, 2017

IPPS hospitals: Review FY 2014 and FY 2015 worksheet S-10 cost report data

Form CMS-2552-10 modified the application of the cost-to-charge ratio for hospital uncompensated and indigent care amounts reported on worksheet S-10. The modification is applied to all FY 2014 and 2015 cost reports, both amended and not amended, for inpatient prospective payment system (IPPS) hospitals eligible for a disproportionate share (DSH) payment adjustment. To benefit from the modified calculations, review worksheet S-10 data to ensure your cost reports pass all edits. Amend your cost report if an edit is flagged; amendments must be received on or before January 2, 2018. Approximately 300 DSH eligible IPPS providers will need to amend their cost reports to correct these edits. We will be sending an amended cost report request letter to providers we were able to identify but please review your affected cost reports to benefit from the modified calculations.

Worksheet S-10 edits ensure:

- Medicare allowable bad debts do not exceed total facility bad debts
- Charity care charges do not exceed total facility charges
- Charges for patient days beyond the indigent care program's length of stay limit (line 20, column 2) are greater than or equal to charges for patient days beyond the indigent care program's length of stay limit (line 25)

For more information:

Transmittal 11 (T-11)

MLN Matters® article SE17031

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*.

Correction to prevent payment on inpatient information only claims for beneficiaries enrolled in MA plans

Provider type affected

This *MLN Matters*® article is intended for hospitals billing Medicare administrative contractors (MACs) for inpatient services provided to Medicare beneficiaries enrolled in a Medicare advantage (MA) plan.

Provider action needed

Change request (CR) 10238 instructs MACs to allow the common working file (CWF) to set edit 5233 on inpatient information only claims billed with condition codes 04 and 30 for investigational device exemption (IDE) studies and clinical studies approved under coverage with evidence development (CED), which will in turn allow the fiscal intermediary standard system (FISS) to zero out payment. CR 10238 contains no new policy. It improves the implementation of existing Medicare payment policies.

Background

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, (Public Law: 99-272), provides for an additional payment to an urban hospital of 100 or more beds that serves a disproportionate share of low-income patients. Part of the calculation used to determine whether or not a hospital is eligible for Medicare disproportionate share hospital (DSH) add-on payments is based on the percentage of days for which the beneficiary was entitled to Medicare Part A and received supplemental security income (SSI) payments from the Social Security Administration (SSA).

The Centers for Medicare & Medicaid Services (CMS) uses claims data to calculate a hospital's percentage of total Medicare days for which Medicare beneficiaries were simultaneously entitled to both SSI and Medicare. In order for MA enrolled inpatient days to be included in this Medicare/SSI fraction, the hospital must submit an informational only bill (type of bill (TOB) 11x) which includes condition code 04 to its MAC.

CMS was notified that a CWF edit that is required to prevent payment on information only claims for MA beneficiaries for IDE studies and clinical studies approved under CED, which should be paid by the Medicare advantage plan, is bypassed for claims billed with condition code (CC) 30, thereby causing a Medicare fee-for-service (FFS) payment in error.

To correct prior claims, hospitals should note that their MAC will reprocess inpatient information only claims with a payment greater than $0, condition codes 04 and 30, one of the approved IDE or CED study numbers listed in the spreadsheet attachment to CR 10238 and an admission discharge date on or after April 1, 2015, and before March 31, 2018, within 90 days of the implementation date of CR 10238.

Additional information

The official instruction, CR 10238, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3898CP.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 27, 2017	Initial article released.

MLN Matters® Number: MM10238
Related CR Release Date: October 27, 2017
Related CR Transmittal Number: R3898CP
Related Change Request (CR) Number: 10238
Effective Date: April 1, 2015
Implementation Date: April 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 January 2, 2018.

Revision of PWK (paperwork) fax/mail cover sheets

Provider type affected

This *MLN Matters*® article is intended for all physicians, providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including durable medical equipment (DME) MACs, and home health and hospices (HH+H) MACs, for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10124 alerts providers that their MAC will provide revised fax/mail cover sheets via hardcopy and/or electronic download. These revised documents are attached to CR 10124. There are three paperwork (PWK) attachments to CR 10124: (1) Medicare Part A fax/mail cover sheet (2) Medicare Part B fax/mail cover sheet and (3) Medicare DME MAC fax/mail cover sheet.

Background

CR 10124 revises the three PWK fax/mail cover sheets to remove health insurance claim number (HICN) from the forms and replace it with Medicare ID. HICN is being removed from the forms as part of the Medicare Access and CHIP Re-authorization Act (MACRA) of 2015, which requires removal of the Social Security number-based HICN from Medicare cards within four years of enactment. These fax/mail cover sheets are used so that providers are able to continue to submit electronic claims, which require additional documentation.

Additional information

The official instruction, CR 10124, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1974OTN.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
November 13, 2017	Initial article released.

MLN Matters® Number: MM10124
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R1974OTN
Related Change Request (CR) Number: 10124
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

Remittance advice remark code, claims adjustment reason code, Medicare Remit Easy Print and PC Print updates

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

Change request (CR) 10270 updates the remittance advice remark codes (RARC) and claims adjustment reason code (CARC) lists and instructs Medicare shared system maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background

The Health Insurance Portability and Accountability Act of 1986 (HIPAA) instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1.

SSMs have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date later than the implementation date specified in CR 10270, MACs must implement on the date specified on the WPC website, available at: *http://wpc-edi.com/Reference/*.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule.

Additional information

The official instruction, CR 10270, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3910CP.pdf*.

See **RARC**, next page

Claim status category codes and claim status codes update

Provider type affected

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

Provider action needed

Change request (CR) 10271 informs MACs about system changes to update, as needed, the claim status codes and claim status category codes used for the Accredited Standards Committee (ASC) X12 276/277 health care claim status request and response and ASC X12 277 health care claim acknowledgment transactions. Make sure your billing staffs are aware of these changes.

Background

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

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

The codes sets are available at *https://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *https://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January 2018 committee meeting will be posted on these sites on or about February 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue notifications regarding the need for future updates to these codes. When instructed, MACs must update their claims systems to ensure that the current version of these codes is used in their claim status responses. MAC and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of change request (CR) 10271.

Note: References in CR 10271 to "277 responses" and "claim status responses" encompass both the ASC X12 277 health care claim status request and response and ASC X12 277 health care claim acknowledgment transactions.

Additional information

The official instruction, CR 10271, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3916CP.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
November 13, 2017	Initial article released.

MLN Matters® Number: MM10271
Related CR Release Date: November 9, 2017
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If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
November 13, 2017	Initial article released.

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CORE 360 uniform use of CARC, RARC and CAGC rule

Provider type affected

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

Provider action needed

Change request (CR) 10268 instructs MACs and shared system maintainers (SSMs) to update systems based on the CORE 360 uniform use of claims adjustment reason codes (CARC), remittance advice remark codes (RARC), and claim adjustment group code (CAGC) rule publication. These system updates are based on the Committee on operating rules for information exchange (CORE) code combination list to be published on or about February 1, 2018. Make sure that your billing staff is aware of these changes.

Background

The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, EFT, and ERA operating rule set that was implemented January 1, 2014, under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1. CR10268 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of CARC and RARC (835) Rule.

CAQH CORE will publish the next version of the code combination list on or about February 1, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2017. This will also include updates based on market-based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare as the industry needs them. You can find CARC and RARC updates at *https://www.wpc-edi.com/reference* and CAQH CORE defined code combination updates at *https://www.caqh.org/CORECodeCombinations.php*.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR 10268, the MACs and the SSMs must get the complete list for both

CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR 10140).

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

Additional information

The official instruction, CR 10268, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3915CP.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

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Transitional drug add-on payment adjustment for patients with AKI

Provider type affected

This *MLN Matters*® article is intended for dialysis facilities submitting claims to Medicare administrative contractors (MACs) provided to Medicare beneficiaries with acute kidney injury (AKI).

Provider action needed

This article is based on change request (CR) 10281, which updates the AKI payment policy regarding transitional drug add-on payment adjustments (TDAPA). Please make sure your billing staffs are aware of these updates.

Background

On June 29, 2015, the Trade Preferences Extension Act of 2015 (TPEA) (Pub. L. 114-27) was enacted. Section 808(a) of the TPEA amended Section 1861(s)(2)(F) of the Social Security Act (the Act) to provide coverage for renal dialysis services furnished on or after January 1, 2017, by a renal dialysis facility or a provider of services paid under Section 1881(b)(14) of the Act to an individual with AKI.

Section 808(b) of the TPEA amended Section 1834 of the Act by adding a new Subsection r that provides for payment for renal dialysis services furnished by renal dialysis facilities or providers of services paid under Section 1881(b)(14) of the Act to individuals with AKI at the end-stage renal disease (ESRD) prospective payment system (PPS) base rate, beginning January 1, 2017. Thus, beginning January 1, 2017, ESRD facilities can furnish dialysis to AKI patients. The AKI provision is available at *https://www.congress.gov/bill/114th-congress/house-bill/1295/text#tocHEE69B51CC87340E2B2AB6A4FA73D2A82*.

The provision provides Medicare payment to hospital-based and freestanding ESRD facilities, for renal dialysis services furnished to pediatric and adult beneficiaries with AKI. Medicare will pay ESRD facilities for the dialysis treatment using the ESRD PPS base rate adjusted by the applicable geographic adjustment factor, that is, the ESRD PPS wage index. In addition to the actual dialysis treatment, the ESRD PPS base rate includes payment for other items and services considered to be renal dialysis services as defined in 42 CFR §413.171 and there will be no separate payment for those services.

Renal dialysis services, as defined in 42 CFR §413.171, are also considered renal dialysis services for patients with AKI. As such, no separate payment would be made for renal dialysis drugs, biologicals, laboratory services, and supplies that are included in the ESRD PPS base rate when they are furnished by an ESRD facility to an individual with AKI.

Other items and services that are furnished to beneficiaries with AKI that are not considered to be renal dialysis services but are related to their dialysis as a result of their AKI, would be separately payable. This includes drugs, biologicals, laboratory services, and supplies that ESRD facilities are certified to furnish and that would otherwise be furnished to a beneficiary with AKI in a hospital outpatient setting.

The Centers for Medicare & Medicaid Services (CMS) implemented the initial payment policy decisions related to AKI in CR 9598. A related article, MM9598, is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9598.pdf*. These policies include:

- The identification of services considered to be AKI using revenue codes, HCPCS codes, and CPT® codes
- Treatment settings
- Treatment limits
- Rules for separately billable items and services

CR 9814 excluded AKI claims from receiving the ESRD network fee reduction, while CR 9987 updated the claims submission policies for erythropoietin stimulating agents (ESAs) for AKI patients. *MLN Matters*® article MM9814 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9814.pdf*.

Under the ESRD PPS drug designation process, CMS provides payment using a TDAPA for new injectable or intravenous drugs and biologicals that qualify under 42 CFR 413.234(c)(1). TDAPA is a payment policy under the ESRD PPS and is only applicable for ESRD beneficiaries. TDAPA is not applicable to the per treatment payment amount that is paid to ESRD facilities for furnishing dialysis to individuals with AKI.

Effective January 1, 2018, TDAPA (as outlined in CR10065, see related *MLN Matters*® article at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10065.pdf*) will make payment to ESRD facilities for furnishing calcimimetics, that is, J0604 - Cinacalcet, oral, 1 mg, (for ESRD on dialysis) and J0606 - Injection, etelcalcetide, 0.1 mg to ESRD beneficiaries, ESRD facilities will not be responsible for furnishing calcimimetics to individuals with AKI. Sensipar (HCPCS code J0604) remains payable under part D for AKI beneficiaries until the utilization is rolled into the bundle at which point it will transition to the bundled payment amount. With regards to Parsabiv (HCPCS code J0606), this drug is not indicated for AKI and therefore no bills should be submitted for Parsabiv in the AKI population.

Note that MACs will return to the provider (RTP) any AKI claim billed with modifier AX on type of bill 72x (AKI) with condition code 84, CPT® code G0491 and one of the following ICD-10 diagnosis codes:

1. N17.0 Acute kidney failure with tubular necrosis
2. N17.1 Acute kidney failure acute cortical necrosis
3. N17.2 Acute kidney failure with medullary necrosis
4. N17.8 Other acute kidney failure

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Implementation of changes in the ESRD PPS and payment for dialysis furnished for AKI in ESRD facilities for 2018

Provider type affected

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

What you need to know

Change request (CR) 10312 implements the 2018 rate updates for the ESRD prospective payment system (PPS) and updates the payment for renal dialysis services furnished to beneficiaries with acute kidney injury (AKI) in ESRD facilities. This *MLN Matters*® (MM) article summarizes these changes. Make sure that your billing staffs are aware of these changes.

Background

Effective January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the ESRD PPS based on the requirements of Section1881(b)(14) of the Social Security Act (the Act) as added by Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA). Section 1881(b)(14)(F) of the Act, as added by Section 153(b) of MIPPA and amended by Section 3401(h) of the Affordable Care Act. As a result, beginning with 2012, and each subsequent year, the Secretary shall annually increase payment amounts by an ESRD market basket increase factor, reduced by the productivity adjustment described in Section 1886(b)(3)(B)(xi)(II) of the Act. The ESRD bundled market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate. Section 217(b)(2) of the Protecting Access to Medicare Act of 2014 (PAMA) included a provision that dictated how the market basket should be reduced for 2018.

In accordance with Section 808(b) of the Trade Preferences Extension Act of 2015 (TPEA), CMS pays ESRD facilities for furnishing renal dialysis services to Medicare beneficiaries with AKI. CR 9598 implemented the payment for renal dialysis services and provides detailed information regarding payment policies. You can view the corresponding *MLN Matters*® article at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9598.pdf*.

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

2018 ESRD PPS updates are as follows:

ESRD PPS base rate:

1. A 0.3 percent update to the 2017 payment rate. ($231.55 x 1.003 =$232.24).
2. A wage index budget-neutrality adjustment factor of 1.000531. ($232.24 x 1.000531 = $232.37)

Wage index:

1. The wage index adjustment will be updated to reflect the latest available wage data.
2. The wage index floor will remain at 0.4000.

Labor-related share:

The labor-related share will remain at 50.673.

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5. N17.9 Acute kidney failure, unspecified
6. T79.5XXA Traumatic anuria, initial encounter
7. T79.5XXD Traumatic anuria, subsequent encounter
8. T79.5XXS Traumatic anuria, sequela
9. N99.0 Post-procedural (acute)(chronic) renal failure

In addition, MACs will RTP AKI claims billed with HCPCS J0604 or J0606.

Additional information

The official instruction, CR 10281 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1941OTN.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

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October 30, 2017	Initial article release date.

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Outlier policy:

CMS made the following updates to the adjusted average outlier service Medicare allowable payment (MAP) amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $42.41.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $37.31.

CMS made the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:

1. The fixed dollar loss amount is $77.54 for adult patients.
2. The fixed dollar loss amount is $47.79 for pediatric patients.

CMS made the following changes to the list of outlier services:

1. Renal dialysis drugs that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the Medicare prescription drug plan finder, are updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. See Attachment A of CR 10312 for a list of 2018 outlier services.
2. The mean dispensing fee of the national drug codes (NDCs) qualifying for outlier consideration is revised to $0.76 per NDC per month for claims with dates of service on or after January 1, 2018. See Attachment A of CR 10312.

Consolidated billing requirements:

The CB requirements for drugs and biologicals included in the ESRD PPS is updated by:

1. Adding the following Healthcare Common Procedure Coding System (HCPCS) codes to the bone and mineral metabolism category:
   a) J0604 - Cinacalcet, oral, 1 mg, (for ESRD on dialysis)
   b) J0606 - Injection, etelcalcetide, 0.1 mg
2. These drugs are payable under the transitional drug add-on payment amount (TDAPA) policy for ESRD beneficiaries and are not separately payable for AKI beneficiaries. The TDAPA was implemented with CR 10065. (See the related *MLN Matters*® article at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10065.pdf*. New drugs and biologicals that are eligible for TDAPA do not qualify as an outlier service.
3. Adding the following HCPCS to the composite rate drugs and biologicals category since these drugs meet the definition of a composite rate drug in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 11, Section 20.3.F and are renal dialysis services:
   - J7030 Infusion, normal saline solution , 1000 cc
   - J7050 Infusion, normal saline solution, 250 cc
   - J7040 Infusion, normal saline solution, sterile
   - J7060 5% dextrose/water (500 ml = 1 unit)
   - J7042 5% dextrose/normal saline (500 ml = 1 unit)
   - J7070 Infusion, d5w, 1000 cc
   - J7120 Ringers lactate infusion, up to 1000 cc
   - J2360 Injection, orphenadrine citrate, up to 60 mg
4. HCPCS J7030, J7050, J7040, J7060, J7042, J7070, J7120, and J2360 do not meet the definition of an outlier service and therefore do not qualify for an outlier payment. In accordance with CR 8978, ESRD facilities should report J7030, J7050, J7040, J7060, J7042, J7070, J7120, and J2360 along with any other composite rate drugs listed in Attachment B of CR 10312.

2018 AKI dialysis payment rate for renal dialysis services:

1. Beginning January 1, 2018, CMS will pay ESRD facilities $232.37 per treatment.
2. The labor-related share is 50.673.
3. The AKI dialysis payment rate will be adjusted for wages using the same wage index that is used under the ESRD PPS.
4. The AKI dialysis payment rate is not reduced for the ESRD quality incentive program (QIP).
5. The TDAPA does not apply to AKI claims.

MACs will not allow a separate payment when the AY modifier is present on type of bill 72x (ESRD) with the HCPCS codes J0604 and J0606.

Additional information

The official instruction, CR 10312, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R237BP.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

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Home health PPS rate update for 2018

Provider type affected

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

What you need to know

Change request (CR) 10310 updates the 60-day national episode rates, the national per-visit amounts, low utilization payment adjustment (LUPA) add-on amounts, the non-routine medical supply payment amounts, and the cost-per-unit payment amounts used for calculating outlier payments under the HH PPS for 2018. Be sure your billing staffs are aware of these changes.

Background

The 2018 HH PPS rate update includes the third year of a three-year phase-in of a reduction to the national, standardized 60-day episode payment amount to account for estimated case-mix growth unrelated to increases in patient acuity (that is, nominal case-mix growth) between 2012 and 2014. The nominal case-mix growth reduction is 0.97 percent. The changes described in MM10310 are implemented through the home health pricer software used by Medicare contractor standard systems.

Market basket update

Section 411(d) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended Section 1895(b)(3)(B) of the Social Security Act (the Act) such that, for home health payments for 2018, the market basket percentage increase shall be one percent. Section 1895(b)(3)(B) of the Act requires that the home health payment update be decreased by two percentage points for those HHAs that do not submit quality data as required by the Secretary of the Department of Health & Human Services (HHS). For HHAs that do not submit the required quality data for 2018, the home health payment update would be -one percent (one percent minus two percentage points).

National, standardized 60-day episode payment

As described in the 2018 HH PPS final rule, in order to calculate the 2018 national, standardized 60-day episode payment rate, the Centers for Medicare & Medicaid Services (CMS) applies a wage index budget neutrality factor of 1.0004 and a case-mix budget neutrality factor of 1.0160 to the previous calendar year's national, standardized 60-day episode rate. To account for nominal case-mix growth from 2012 to 2014, CMS applies a payment reduction of 0.97 percent to the national, standardized 60-day episode payment rate. Lastly, the national, standardized 60-day episode payment rate is updated by the 2018 HH payment update percentage of one percent for HHAs that submit the required quality data and by one percent minus two percentage points, or -one percent, for HHAs that do not submit quality data. These two-episode payment rates are shown in Tables 1 and 2 (see page 26). These payments are further adjusted by the individual episode's case-mix weight and by the wage index.

National per-visit rates

To calculate the 2018 national per-visit payment rates, CMS starts with the 2017 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0010 to ensure budget neutrality for LUPA per-visit payments after applying the 2018 wage index. The per-visit rates are then updated by the 2018 HH payment update of 1 percent for HHAs that submit the required quality data and by -one percent for HHAs that do not submit quality data. The per-visit rates are shown in Tables 3 and 4 (see page 26).

Non-routine supply payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the 2018 NRS conversion factors, CMS updates the 2017 NRS conversion factor by the 2018 HH payment update of 1 percent for HHAs that submit the required quality data and by -one percent for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for 2018 payments for HHAs that do submit the required quality data is shown in Table 5a and the payment amounts for the various NRS severity levels are shown in Table 5b. The NRS conversion factor for 2018 payments for HHAs that do not submit quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

Table 5a: 2018 NRS conversion factor for HHAs that DO submit the required quality data

2017 NRS conversion factor	2018 HH payment update	2018 NRS conversion factor
$52.50	X 1.01	$53.03

Table 5b: 2018 relative weights and payment amounts for the six-severity NRS system for HHAs that DO submit quality data

Severity level	Points (scoring)	Relative weight	2018 NRS payment amounts
1	0	0.2698	$14.31
2	1 to 14	0.9742	$51.66
3	15 to 27	2.6712	$141.65
4	28 to 48	3.9686	$210.45
5	49 to 98	6.1198	$324.53

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Severity level	Points (scoring)	Relative weight	2018 NRS payment amounts
6	99+	10.5254	$558.16

Table 6a: 2018 NRS conversion factor for HHAs that DO NOT submit the required quality data

2017 NRS conversion factor	2018 HH payment update percentage minus 2 percentage points	2018 NRS conversion factor
$52.50	X 0.99	$51.98

Table 6b: 2018 relative weights and payment amounts for the six-severity NRS system for HHAs that DO NOT submit quality data

Severity level	Points (scoring)	Relative weight	2018 NRS payment amounts
1	0	0.2698	$14.02
2	1 to 14	0.9742	$50.64
3	15 to 27	2.6712	$138.85
4	28 to 48	3.9686	$206.29
5	49 to 98	6.1198	$318.11
6	99+	10.5254	$547.11

Sunset of the rural add-on provision

Section 210 of MACRA extended the rural add-on of a three-percent increase in the payment amount for HH services provided in a rural area for episodes and visits ending before January 1, 2018. Therefore, for episodes and visits that end on or after January 1, 2018, a rural add-on payment will not apply.

Methodology for calculating outlier payments

In the 2017 HH PPS final rule (81 FR 76702), CMS finalized changes to the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. This change in methodology allows for more accurate payment for outlier episodes, accounting for both the number of visits during an episode of care and also the length of the visits provided. Using this approach, CMS now converts the national per-visit rates into per 15-minute unit rates. These per 15-minute unit rates are used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. The cost-per-unit payment rates used for the calculation of outlier payments are shown in Tables 7a and 7b. The fixed-dollar loss (FDL) ratio remains 0.55 and the loss-sharing ratio remains 0.80.

Table 7a – cost-per-unit rates for calculating outlier payments for HHAs that DO submit required quality data

HH discipline	Average minutes per visit	2018 per-visit payment	Cost per unit (one unit = 15 minutes)
Home health aide	63.0	$64.94	$15.46
Medical social services	56.5	$229.86	$61.02
Occupational therapy	47.1	$157.83	$50.26
Physical therapy	46.6	$156.76	$50.46
Skilled nursing	44.8	$143.40	$48.01
Speech-language pathology	48.1	$170.38	$53.13

Table 7b – cost-per-unit rates for calculating outlier payments for HHAs that DO NOT submit required quality data

HH discipline	Average minutes per visit	2018 per-visit payment	Cost per unit (one unit = 15 minutes)
Home health aide	63.0	$63.65	$15.15
Medical social services	56.5	$225.31	$59.82
Occupational therapy	47.1	$154.70	$49.27
Physical therapy	46.6	$153.65	$49.46
Skilled nursing	44.8	$140.56	$47.06
Speech-language pathology	48.1	$167.00	$52.08

Additional information

The official instruction, CR 10310, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3888CP.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
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Table 1: For HHAs that DO submit quality data – national, standardized 60-day episode amount for 2018

2017 national, standardized 60-day episode payment	Wage index budget neutrality factor	Case-mix weights budget neutrality factor	Nominal case-mix growth adjustment	2018 HH payment update	2018 national, standardized 60-day episode payment
$2,989.97	X 1.0004	X 1.0160	X 0.9903	X 1.01	$3,039.64

Table 2: For HHAs that DO NOT submit quality data – national, standardized 60-day episode amount for 2018

2017 national, standardized 60-day episode payment	Wage index budget neutrality factor	Case-mix weights budget neutrality factor	Nominal case-mix growth adjustment	2018 HH payment update	2018 national, standardized 60-day episode payment
$2,989.97	X 1.0004	X 1.0160	X 0.9903	X 0.99	$2,979.45

Table 3: For HHAs that DO submit quality data – 2018 national per-visit amounts for LUPAs and outlier calculations

HH discipline type	2017 per-visit payment	Wage index budget neutrality factor	2018 HH payment update	2018 per-visit payment
Home health aide	$64.23	X 1.0010	X 1.01	$64.94
Medical social services	$227.36	X 1.0010	X 1.01	$229.86
Occupational therapy	$156.11	X 1.0010	X 1.01	$157.83
Physical therapy	$155.05	X 1.0010	X 1.01	$156.76
Skilled nursing	$141.84	X 1.0010	X 1.01	$143.40
Speech-language pathology	$168.52	X 1.0010	X 1.01	$170.38

Table 4: For HHAs that DO NOT submit quality data – 2018 national per-visit amounts for LUPAs and outlier calculations

HH discipline type	2017 per-visit payment	Wage index budget neutrality factor	2018 HH payment update	2018 per-visit payment
Home health aide	$64.23	X 1.0010	X 0.99	$63.65
Medical social services	$227.36	X 1.0010	X 0.99	$225.31
Occupational therapy	$156.11	X 1.0010	X 0.99	$154.70
Physical therapy	$155.05	X 1.0010	X 0.99	$153.65
Skilled nursing	$141.84	X 1.0010	X 0.99	$140.56
Speech-language pathology	$168.52	X 1.0010	X 0.99	$167.00

Annual update of HCPCS codes used for home health consolidated billing enforcement

Provider type affected

This *MLN Matters*® article is intended for home health agencies (HHAs) and other providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

Provider action needed

Change request (CR) 10308 provides the 2018 annual update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of home health services. Make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to MACs will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by an HHA).

In such cases, Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually to reflect the yearly changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, “K” codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates. That is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for HH services provided under a HH plan of care is made to the HHA. This requirement is in Medicare regulations at 42 CFR 409.100 and in Medicare instructions in Chapter 10, Section 20 of the *Medicare Claims Processing Manual*.

The recurring updates in CR 10308 provide annual HH consolidated billing updates effective January 1, 2018. The following HCPCS codes are added to the HH consolidated billing therapy code list:

- 97763 – Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
  - This code replaces 97762.
- G0515 – Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes
  - This code replaces 97532.

Additional information

The official instruction, CR 10086, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3877CP.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
November 13, 2017	Initial article released.

MLN Matters® Number: MM10308
Related CR Release Date: October 6, 2017
Related CR Transmittal Number: R3877CP
Related Change Request (CR) Number: 10308
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Care coordination services and payment for RHCs and FQHCs

Provider type affected

This *MLN Matters*® article is intended for rural health clinics (RHCs) and federally qualified health centers (FQHCs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10175 provides instructions for payment to RHCs billing under the all-inclusive rate (AIR), and FQHCs billing under the prospective payment system (PPS), for care coordination services for dates of service on or after January 1, 2018.

Background

As authorized by §1861(aa) of the Social Security Act, RHCs and FQHCs are paid for physician services and services and supplies incident to physician services. Care coordination services are RHC and FQHC services, but payment for the additional costs associated with certain care coordination services are not included in the RHC AIR or the FQHC PPS rate. In the 2016 Medicare physician fee schedule (PFS) final rule (80 FR 71080), Centers for Medicare & Medicaid Services (CMS) finalized requirements and a payment methodology for chronic care management (CCM) services furnished by RHCs and FQHCs. Effective January 1, 2016, CCM payment to RHCs and FQHCs is based on the Medicare PFS national non-facility payment rate when CPT® code 99490 is billed alone or with other payable services on a RHC or FQHC claim. The rate is updated annually and there is no geographic adjustment. Revisions to the CCM requirements for RHCs and FQHCs were in the 2017 PFS final rule (81 FR 80256) for services furnished on or after January 1, 2017.

In the 2017 PFS final rule (81 FR 80225), CMS established separate payment, beginning January 1, 2017, for practitioners billing under the PFS, for complex CCM services, general behavioral health integration (BHI) services, and a psychiatric collaborative care model (CoCM). To allow payment to RHCs and FQHCs for these new services, CMS finalized in the 2018 physician fee schedule final rule to revise payment for care coordination services in RHCS and FQHCs by establishing two new G codes for use by RHCs and FQHCs, effective January 1, 2018. **The first new G code will be a general care management code for RHCs and FQHCs with the payment amount set at the average of the three national non-facility PFS payment rates for the CCM and general BHI codes. The second new G code for RHCs and FQHCs will be a Psychiatric CoCM code with the payment amount set at the average of the two national non-facility PFS payment rates for psychiatric CoCM services**. RHC or FQHC claims submitted using CPT® 99490 for dates of service on or after January 1, 2018, will be denied.

Effective for dates of service on or after January 1, 2018, RHCs and FQHCs will be paid for general care management services when G0511 is billed alone or with other payable services on a RHC or FQHC claim. Payment for G0511 is set at the average of the three national non-facility PFS payment rates for the CCM (CPT® code 99490 and CPT® code 99487) and general BHI (CPT® code 99484). The rate is updated annually based on the PFS amounts and coinsurance applies. This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.

Effective for dates of service on or after January 1, 2018, RHCs and FQHCs will be paid for psychiatric CoCM services when G0512 is billed alone or with other payable services on an RHC or FQHC claim. Payment for G0512 is set at the average of the two national non-facility PFS payment rates for CoCM (CPT® code 99492 and CPT® code 99493). The rate is updated annually based on the PFS amounts and coinsurance applies. This code could only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period.

General care management (G0511) requirements: RHCs and FQHCs can bill the new general care management G code when the following requirements are met:

1. **Initiating visit**: An evaluation management (E/M), annual wellness visit (AWV), or initial preventive physical examination (IPPE) visit furnished by a physician, nurse practitioner (NP), physician assistants (PA), or certified nurse-midwives (CNM) has occurred no more than one-year prior to commencing care coordination services. This would be billed as an RHC or FQHC visit.
2. **Beneficiary consent**: Has been obtained during or after the initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff; can be written or verbal, must be documented in the medical record and includes information:
   - On the availability of care coordination services and applicable cost-sharing
   - That only one practitioner can furnish and be paid for care coordination services during a calendar month
   - On the right to stop care coordination services at any time (effective at the end of the calendar month)
   - Permission to consult with relevant specialists.
3. **Billing requirements**: At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the RHC or FQHC physician, NP, PA, or CNM, and b) by

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an RHC or FQHC practitioner, or by clinical personnel under general supervision.

4. **Patient eligibility**: Patient must have:
   - **Option A**: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline, OR
   - **Option B**: Any behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services.

5. **Requirement service elements**

   For patients meeting the eligibility requirements of Option A, the RHC or FQHC must meet all of the following requirements:
   - Structured recording of patient health information using certified EHR technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care
   - 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
   - Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications
   - Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re) assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed
   - Care plan information made available electronically (including fax) in a timely manner within and outside the RHC or FQHC as appropriate and a copy of the plan of care given to the patient and/or caregiver
   - Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
   - Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record
   - Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, internet, or other asynchronous non-face-to-face consultation methods.

For patients meeting the eligibility requirements of Option B, the RHC or FQHC must meet all of the following requirements:
- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
- Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/ or psychiatric consultation)
- Continuity of care with a designated member of the care team.

Psychiatric CoCM (G0512) requirements: RHCs and FQHCs can bill the psychiatric CoCM G code when the following requirements are met:

1. **Initiating visit**: An E/M, AWV, or IPPE visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric CoCM services. This would be billed as an RHC or FQHC visit.
2. **Beneficiary consent**: Has been obtained during or after the initiating visit and before provision of care coordination services by RHC or FQHC practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:
   - Information on the availability of care coordination services and applicable cost-sharing
   - That only one practitioner can furnish and be paid for care coordination services during a calendar month
   - That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month)

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- The patient is giving permission to consult with relevant specialists

3. **Billing requirements**: At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric CoCM services, furnished a) under the direction of the RHC or FQHC practitioner, and b) by an RHC or FQHC practitioner or Behavioral Health Care Manager under general supervision.
4. **Patient eligibility**: Patient must have a behavioral health or psychiatric condition that is being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants psychiatric CoCM services.
5. **Requirement service elements**: Psychiatric CoCM requires a team that includes the following:

   RHC or FQHC practitioner (physician, NP, PA, or CNM) who:

   - Directs the behavioral health care manager or clinical staff
   - Oversees; the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed
   - Remains involved through ongoing oversight, management, collaboration and reassessment

Behavioral health care manager who:

- Provides assessment and care management services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the RHC or FQHC practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant
- Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team
- Is available to contact the patient outside of regular RHC or FQHC hours as necessary to conduct the behavioral health care manager's duties

Psychiatric consultant who:

- Participates in regular reviews of the clinical status of patients receiving CoCM services;
- Advises the RHC or FQHC practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for

beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments

- Facilitate referral for direct provision of psychiatric care when clinically indicated

MACs will apply coinsurance and deductible to HCPCS codes G0511 and G0512 on FQHC claims.

Additional information

The official instruction, CR 10175, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1899OTN.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
November 13, 2017	The article was revised to correct statements in *Background* (**in bold**).
November 8, 2017	Initial article released.

MLN Matters® Number: MM10175 *Revised*
Related CR Release Date: August 11, 2017
Related CR Transmittal Number: R1899OTN
Related Change Request (CR) Number: 10175
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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

***Note*: *Note**: This article was revised November 3, 2017, to reflect an updated change request (CR). That CR changed the instruction to the MACs for searching files- see note at end of "Background" section. The CR release date, transmittal number and link to the transmittal also changed. All other information is unchanged. This information was previously published in the September 2017 Medicare A Connection, pages 62-63*.

Provider types affected

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

Provider action needed

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

Background

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

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

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

Payment for the following CPT® or HCPCS codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2017 -July 31, 2018:

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

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

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

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

Providers should note that:

- All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

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- The annual Part B deductible and coinsurance amounts do not apply.

Note: MACs will reprocess any previously processed and paid claims for the current flu season, that were paid using influenza vaccine payment allowances other than the allowances published in the influenza vaccine pricing website for the 2017/2018 season that began August 1, 2017. MACs will initiate the mass adjustment process to reprocess claims by November 1, 2017. A MAC that requires more time to meet this deadline may contact its contracting officer's representative (COR) for additional direction.

Additional information

The official instruction, CR 10224, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3908CP.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
November 3, 2017	The article was revised to reflect an updated change request (CR). That CR changed the instruction to the MACs for searching files- see note at end of *Background* section. The CR release date, transmittal number and link to the transmittal also changed.

Date of change	Description
November 2, 2017	This article was revised to add a reference to *MLN Matters*® article SE17026 which 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.)
August 18, 2017	Initial article released.

MLN Matters® Number: MM10224 *Revised*
Related CR Release Date: November 3, 2017
Related CR Transmittal Number: R3908CP
Related Change Request (CR) Number: CR 10224
Effective Date: August 1, 2017
Implementation Date: No later than October 2, 2017

October 2017 integrated outpatient code editor specifications version 18.3

Note: *This article was revised November 3, 2017, to reflect the revised change request (CR) 10230 issued on that same date. In the article, the modification table was updated to include the revisions to several age and gender edits (row 1 of the table) and to add reference to the conditional bilateral list in row 10 of the table. Also, the CR release date, transmittal number and the web address for accessing the CR are revised. All other information remains the same. This information was previously published in the September 2017 Medicare A Connection, pages 55-57.*

Provider type affected

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

Provider action needed

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

Background

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

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

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

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

Effective date	Edits affected	Modification
10/1/2017	2,3	Revisions to several age and gender edits (details in Summary of Data Changes of CR 10230).

Effective date	Edits affected	Modification
10/1/2017	1, 2, 3, 5, 86	Updated diagnosis code editing for validity, age, gender and manifestation based on the FY 2018 ICD-10-CM code revisions to the Medicare code editor (MCE).
10/1/2017	29	Updated the mental health diagnosis list based on the FY 2018 ICD-10-CM code revisions.
10/1/2017	95	Modify the effective date for edit 95 to 10/1/2017.
4/1/2017	30, 95	Update the list of add-on procedure codes that are not counted towards the daily and weekly requirements for number of partial hospitalization program (PHP) services. Procedure codes 90833, 90836, and 90838 are removed from the list; 90785 remains (see special processing logic, Appendix C-a flowchart and Appendix O of CR 10230).
7/1/2017	22	Add ZC (Merck/ Samsung Bioepis) to the list of valid modifiers.
7/1/2017	94	Add modifier ZC as a biosimilar manufacturer modifier applicable for HCPCS Q5102.
10/1/2016	99	Add HCPCS J2505 (Injection, pegfilgrastim 6mg) to the list of HCPCS excepted from requiring an OPPS procedure on the same claim (see special processing logic).

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Effective date	Edits affected	Modification
7/1/2017	41, 65	Add new revenue code 1006 to the list of valid revenue codes and to the list of revenue codes not recognized by Medicare.
10/1/2017		Update the following lists for the release (see quarterly data files): ▪ Conditional bilateral list (R1 – code added to list) ▪ Edit 99 exclusion list (add new codes to exception list) ▪ Comprehensive ambulatory payment classification (APC) ranking ▪ Comprehensive APC code Pairs (correction to two APC Pairs missing complexity-adjusted APC assignment retroactive for 2016 service dates) ▪ New data file report for comprehensive APCs (includes list of procedures, rank and flag for eligibility of complexity-adjusted APC) ▪ Device-procedure list (edit 92) ▪ Terminated device-procedures for device credit (device offset amount corrections; updated code list) ▪ Non-standard CT scan (updated code list)
8/1/2017	68	Implement national coverage determination (NCD) mid-quarter effective editing for procedure codes 0006U, 0007U, 0008U, 0009U, 0010U, 0011U, 0012U, 0013U, 0014U, 0015U, 0016U, 0017U.
5/25/2017	68	Implement NCD mid-quarter effective editing for procedure code 93668.
4/3/2017	68	Implement NCD mid-quarter effective editing for HCPCS A4575 and E0446.
10/1/2017		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
10/1/2017	20, 40	Implement version 23.3 of the NCCI (as modified for applicable outpatient institutional providers).

Additional information

The official instruction, CR 10230, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3907CP.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: MM10230 *Revised*
Related CR Release Date: November 3, 2017
Related CR Transmittal Number: R3907CP
Related Change Request (CR) Number: 10230
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

Update to RHC all-inclusive rate payment limit for 2018

Provider type affected

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

What you need to know

The RHC payment limit per visit for 2018 is $83.45 effective January 1, 2018, through December 31, 2018. The 2018 RHC payment limit reflects a 1.4 percent increase above the 2017 payment limit of $82.30.

Background

Medicare Part B payment to RHCs is 80 percent of the all-inclusive rate (AIR), subject to a payment limit for medically necessary medical, and qualified preventive face-to-face visits with a practitioner and a Medicare beneficiary for RHC services. As authorized by Section 1833(f) of the Social Security Act (the Act), the payment limits for a subsequent year shall be increased in accordance with the rate of increase in the Medicare economic index (MEI). Based on historical data through second quarter 2017, the 2018 MEI is 1.4 percent. The RHC payment limit per visit for 2018 is $83.45 effective January 1, 2018, through December 31, 2018. The 2018 RHC payment limit reflects a 1.4 percent increase above the 2017 payment limit of $82.30.

Additional information

The official instruction, CR 10333, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3919CP.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
November 13, 2017	Initial article released.

MLN Matters® Number: MM10333
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R3919CP
Related Change Request (CR) Number: 10333
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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results in a negative AIF update. Therefore, the AIF for CY 2018 is 1.1 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Additional information

The official instruction, CR 10323, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3893CP.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 27, 2017	Initial article released.

MLN Matters® Number: MM10323
Related CR Release Date: October 27, 2017
Related CR Transmittal Number: R3893CP
Related Change Request (CR) Number: CR 10323
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

New positron emission tomography radiopharmaceutical/ tracer unclassified codes

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

Positron emission tomography (PET) is a nuclear medicine imaging study used to detect normal and abnormal tissues. All PET scan services are billed using PET or PET/ computed tomography (CT) *Current Procedural Terminology* (CPT®) codes 78459, 78491, 78492, 78608, and 78811 through 78816. Each of these CPT® codes always requires the use of a radiopharmaceutical code, also known as a tracer code. Therefore, an applicable tracer code, along with an applicable CPT® code, is necessary for claims processing of any PET scan services.

While there are a number of PET tracers already billable for a diverse number of medical indications, there have been, and may be in the future, additional PET indications that might require a new PET tracer. Under those circumstances, the process to request/approve/implement a new code could be time-intensive.

To help alleviate inordinate spans of time between when a coverage determination is made and when it can be fully implemented via valid claims processing, the Centers for Medicare & Medicaid Services (CMS) has created two new PET radiopharmaceutical unclassified tracer codes that can be used temporarily pending the creation/approval/ implementation of permanent CPT® codes that would later specifically define their function.

Effective January 1, 2017, with the January 2017 quarterly Healthcare Common Procedure Coding System (HCPCS) update, the two temporary PET HCPCS codes are:

- A9597 - Positron emission tomography radiopharmaceutical, diagnostic, for tumor identification, not otherwise classified
- A9598 - Positron emission tomography radiopharmaceutical, diagnostic, for non-tumor identification, not otherwise classified

Make sure that your billing staffs are aware of these changes.

Note: HCPCS codes A9597 and A9598 are **not** to be reported for any CMS-approved PET indication where a dedicated PET radiopharmaceutical is already assigned. In other words, HCPCS A9597 and A9598 are not replacements for currently approved PET radiopharmaceuticals A9515, A9526, A9552, A9555, A9580, A9586, A9587, or A9588**.**

Background

Effective with dates of service on or after January 1, 2018, the above two HCPCS codes shall be used ONLY AS NECESSARY FOR AN INTERIM PERIOD OF TIME under the circumstances explained below:

(1) After U.S. Food and Drug Administration (FDA) approval of a PET oncologic indication, or

(2) After CMS approves coverage of a new PET indication, **BUT**,

ONLY IF either of the above situations requires the use of a dedicated PET radiopharmaceutical/tracer that is currently non-existent.

Once permanent replacement codes are implemented via a subsequent CMS CR, that subsequent CR will also discontinue use of the temporary code for that PET particular indication.

Effective for claims with dates of service on and after January 1, 2018, MACs will ensure when PET tracer code A9597 or A9598 are present on a claim, that claim must also include:

- An appropriate PET HCPCS code, either 78459, 78491, 78492, 78608, 78811, 78812, 78813, 78814, 78815, or 78816
- If tumor-related, either the PI or PS modifier as appropriate
- If clinical trial-, registry-, or study-related outside of NCD 220.6.17 PET for solid tumors, clinical trial modifier Q0
- If Part A outpatient and study-related outside of NCD 220.6.17 PET for solid tumors, also include condition code 30 and ICD-10 diagnosis Z00.6
- If clinical trial-, registry-, or study-related, all claims require the eight-digit clinical trial number

Effective for claims with dates of service on and after

See **PET**, next page

Therapy cap values for calendar year 2018

Provider type affected

This *MLN Matters*® article is intended for physicians, therapists, and other providers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10341 provides the amounts for outpatient therapy caps for 2018. For physical therapy and speech-language pathology combined, the 2018 cap is $2,010. For occupational therapy, the 2018 cap is $2,010. Make sure that your billing staffs are aware of these therapy cap value updates.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as "therapy caps." The therapy caps are updated each year based on the Medicare economic index.

Section 5107 of the Deficit Reduction Act of 2005 required an exceptions process to the therapy caps for reasonable and medically necessary services. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy caps exceptions process through December 31, 2017.

Additional information

The official instruction, CR 10341, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3918CP.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
November 13, 2017	Initial article released.

MLN Matter® Number: MM10341
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R3918CP
Related Change Request (CR) Number: 10341
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

PET

previous page

January 1, 2018, MACs for Part A shall line-item deny and MACs for Part B shall line-item reject, PET claims for A9597 or A9598 that do not include the above elements, as appropriate. When denying or rejecting line items, MACs will use the following remittance messages:

- Remittance advice remark code (RARC) N386
- Claim adjustment reason code (CARC) 50, 96, 16, and/or 119
- Group code CO (contractual obligation) assigning financial liability to the provider

MACs will not search for and adjust previously processed claims but will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 10319, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3911CP.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
November 16, 2017	Initial article released.

MLN Matters® Number: MM10319
Related CR Release Date: November 9, 2017
Related CR Transmittal Number: R3911CP
Related Change Request (CR) Number: 10319
Effective Date: January 1, 2018
Implementation Date: December 11, 2017 – MACs; April 2, 2018 - FISS, 2018

Upcoming provider outreach and educational events

Internet-based PECOS training by appointment

Date: By appointment
Type of Event: Face-to-face
https://medicare.fcso.com/Events/0324673.asp

Topic: Targeted Probe and Educate: Reducing provider burden

Date: Thursday, December 14
Time: 10:30-noon
Type of Event: Webcast
https://medicare.fcso.com/Events/0393648.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 *https://gm1.geolearning.com/geonext/fcso/opensite.geo*, 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 October 26, 2017

MLN Connects® for October 26, 2017
View this edition as a PDF

News & Announcements

- New Medicare Numbers/Cards: Coordination of Benefits
- Hospice QRP: Register for HEART Pilot Study by October 31
- MIPS: Participate in Field Testing of Episode-Based Cost Measures by November 15
- Physician Compare Preview Period Closes November 17

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- Definition of a Hospital: Primarily Engaged Requirement Call — November 2
- Preventive Care and Health Screenings for Persons with Disabilities Webinar — November 2
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16
- Comparative Billing Report on Emergency Department Services Webinar — December 13

Medicare Learning Network Publications & Multimedia

- Quality Payment Program in 2017: MIPS APMs Web-Based Training Course —New

- HHA Star Rating Call: Audio Recording and Transcript — New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program *MLN Matters*® article — Revised
- General Equivalence Mappings FAQs Booklet — Revised
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Web-Based Training Course — Reminder

Find out first: Subscribe to First Coast *eNews*

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

MLN Connects® for November 2, 2017

MLN Connects® for November 2, 2017
View this edition as a PDF

News & Announcements

- ESRD PPS: Updates to Policies and Payment Rates
- New Medicare Card: Provider Ombudsman Announced
- IRF and LTCH Quality Reporting Programs Submission Deadline: November 15
- Physician Compare Preview Period Extended to December 1
- Hospitals: Take Action before Meaningful Use Attestation Beginning January 2
- SNF Quality Reporting Program Submission Deadline Extended to May 15
- eCQM Value Set Addendum: Updated Technical Release Notes
- Administrative Simplification Enforcement and Testing Tool
- Antipsychotic Drug use in Nursing Homes: Trend Update
- CMS Offers Medicare Enrollment Relief for Americans Affected by Recent Disasters
- November is Home Care and Hospice Month

Provider Compliance

- Advanced Life Support Ambulance Services: Insufficient Documentation — Reminder

Claims, Pricers, & Codes

- Outpatient Claims: Correcting Deductible and Coinsurance for Code G0473

Upcoming Events

- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16

Medicare Learning Network Publications & Multimedia

- QRUR Webcast: Audio Recording and Transcript — New
- ICD-10-CM/PCS the Next Generation of Coding Booklet — Revised
- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Reminder
- Medicare Home Health Benefit Web-Based Training Course — Reminder
- Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Reminder
- Resources for Medicare Beneficiaries Booklet — Reminder
- Medicare Ambulance Transports Booklet — Reminder
- SNF Billing Reference Booklet — Reminder
- Items and Services Not Covered under Medicare Booklet — Reminder
- Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Reminder

Social Security Number Removal Initiative (SSNRI)

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

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

MLN Connects® Special Edition – November 2, 2017

In This Edition:

- Physician Fee Schedule Final Policy, Payment, and Quality Provisions for CY 2018
- Hospital OPPS and ASC Payment System and Quality Reporting Programs Changes for 2018
- HHAs: Payment Changes for 2018
- Quality Payment Program Rule for Year 2

Physician Fee Schedule Final Policy, Payment, and Quality Provisions for CY 2018

On November 2, CMS issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2018.

The overall update to payments under the PFS based on the finalized CY 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience Act of 2014. After applying these adjustments, and the budget neutrality adjustment to account for changes in Relative Value Units, all required by law, the final 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Changes in valuation for specific services
- Payment rates for nonexcepted off-campus provider-based hospital departments
- Medicare telehealth services
- Malpractice relative value units
- Care management services
- Improvement of payment rates for office-based behavioral health services
- Evaluation and management comment solicitation
- Emergency department visits comment solicitation
- Solicitation of public comments on initial data collection and reporting periods for Clinical Laboratory Fee Schedule
- Part B drugs: Payment for biosimilar biological products
- Part B drug payment: Infusion drugs furnished through an item of durable medical equipment
- New care coordination services and payment for rural health clinics and federally-qualified health centers
- Appropriate use criteria for advanced diagnostic imaging
- Medicare Diabetes Prevention Program expanded model
- Physician Quality Reporting System
- Patient relationship codes
- Medicare Shared Savings Program
- 2018 Value Modifier

For More Information:

- *Final Rule*
- *Press Release*: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices
- See the full text of this excerpted *CMS Fact Sheet* (issued November 2).

Hospital OPPS and ASC Payment System and Quality Reporting Programs Changes for 2018

On November 1, CMS issued the CY 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule with comment period, which includes updates to the 2018 rates and quality provisions and other policy changes. CMS adopted a number of policies that will support care delivery; reduce burdens for health care providers, especially in rural areas; lower beneficiary out of pocket drug costs for certain drugs; enhance the patient-doctor relationship; and promote flexibility in healthcare.

CMS is increasing the OPPS payment rates by 1.35 percent for 2018. The change is based on the hospital market basket increase of 2.7 percent minus both a 0.6 percentage point adjustment for multi-factor productivity and a 0.75 percentage point adjustment required by law. After considering all other policy changes under the final rule, including estimated spending for pass-through payments, CMS estimates an overall impact of 1.4 percent payment increase for providers paid under the OPPS in CY 2018.

CMS updates ASC payments annually by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). The Medicare statute specifies a Multi-Factor Productivity (MFP) adjustment to the ASC annual update. For CY 2018, the CPI-U update is 1.7 percent. The MFP adjustment is 0.5 percent, resulting in a CY 2018 MFP-adjusted CPI-U update factor of 1.2 percent. Including enrollment, case-mix, and utilization changes, total ASC payments are projected to increase approximately 3 percent in 2018.

The Final Rule Includes:

- Patients over Paperwork Initiative
- Payment for drugs and biologicals purchased through the 340B drug pricing program
- Supervision of hospital outpatient therapeutic services
- Packaging of low-cost drug administration services
- Inpatient only list
- High cost/low cost threshold for packaged skin substitutes
- Revisions to the laboratory date of service policy

See **SPECIAL**, next page

SPECIAL

previous page

- Partial Hospitalization Program rate setting
- Comment solicitation on ASC payment reform
- ASC covered procedures list
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program

For More Information:

- *Final Rule*
- *Press Release*: CMS Finalizes Policies that Lower Out-of-Pocket Drug Costs and Increase Access to High-Quality Care

See the full text of this excerpted *CMS Fact Sheet* (issued November 1).

HHAs: Payment Changes for 2018

On November 1, CMS issued a final rule that updates the CY 2018 Medicare payment rates and the wage index for Home Health Agencies (HHAs) serving Medicare beneficiaries. The rule also finalizes proposals for the Home Health Value-Based Purchasing Model and the Home Health Quality Reporting Program.

CMS projects that Medicare payments to HHAs in CY 2018 will be reduced by 0.4 percent, or $80 million, based on the finalized policies. This decrease reflects the effects of a one percent home health payment update percentage ($190 million increase); a -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9 percent ($170 million decrease); and the sunset of the rural add-on provision ($100 million decrease).

The Final Rule Includes:

- Patients over Paperwork Initiative
- Annual home health payment update percentage
- Adjustment to reflect nominal case-mix growth
- Sunset of the rural add-on provision

For More Information:

- *Final Rule*
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (issued November 1).

Quality Payment Program Rule for Year 2

On November 2, CMS issued the final rule with comment for the second year of the Quality Payment Program (CY 2018), as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as well as an interim final rule with comment. We finalized policies for Year 2 of the Quality Payment Program to further reduce your burden and give you more ways to participate successfully. We are keeping many of our transition year policies and making some minor changes.

The final rule Includes:

- Weighting the Merit-based Incentive Payment System (MIPS) Cost performance category to 10 percent of your total MIPS final score, and the Quality performance category to 50 percent
- Raising the MIPS performance threshold to 15 points in Year 2
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2 for the Advancing Care Information performance category, and giving a bonus for using only 2015 CEHRT
- Awarding up to 5 bonus points on your MIPS final score for treatment of complex patients
- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0 percent of the MIPS final score for clinicians impacted by Hurricanes Irma, Harvey and Maria and other natural disasters
- Adding 5 bonus points to the MIPS final scores of small practices
- Adding Virtual Groups as a participation option for MIPS
- Issuing an interim final rule with comment for extreme and uncontrollable circumstances where clinicians can be automatically exempt from these categories in the transition year without submitting a hardship exception application
- Decreasing the number of doctors and clinicians required to participate as a way to provide further flexibility by excluding individual MIPS eligible clinicians or groups with =$90,000 in Part B allowed charges or =200 Medicare Part B beneficiaries
- Providing more detail on how eligible clinicians participating in selected Advanced Alternative Payment Models (APMs) will be assessed under the APM scoring standard
- Creating additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option

For More Information:

- *Final Rule*
- *Fact Sheet*
- *Executive Summary*
- *Press Release*: CMS Finalizes Policies that Reduce Provider Burden, Lower Drug Prices
- *Quality Payment Program* website
- *Register* for a webinar on November 14

MLN Connects® for November 9, 2017

MLN Connects® for November 9, 2017
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News & Announcements

- New Medicare Card: Help Notify Your Patients
- Medicare Diabetes Prevention Program Expanded Model Implementation
- Hospital Value-Based Purchasing Program Results for FY 2018
- Low Volume Appeals Settlements
- Hospice Item Set Data Freeze: November 15
- Draft 2018 CMS QRDA III Implementation Guide: Submit Comments by November 17
- CMS Innovation Center New Direction RFI: Submit Comments by November 20
- Therapeutic Shoe Inserts: Comment on DMEPOS Quality Standards through December 11
- Quality Payment Program Resources in New Location
- Post-Acute Care: Quality Reporting Program Quick Reference Guides Available
- Provider and Pharmacy Access during Public Health Emergencies
- Raising Awareness of Diabetes in November

Provider Compliance

- Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims

Upcoming Events

- Quality Payment Program Year 2 Overview Webinar — November 14
- SNF Value-Based Purchasing Program FY 2018 Final Rule Call — November 16
- Quality Payment Program Virtual Groups Train-the-Trainer Webinar — November 17
- Quality Payment Program Year 2 Final Rule Call — November 30
- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- LTCH Quality Reporting Program In-Person Training — December 6 and 7

Medicare Learning Network Publications & Multimedia

- Quality Payment Program in 2017: Advanced Alternative Payment Models Web-Based Training Course — New
- Medicare FFS Response to the 2017 California Wildfires *MLN Matters®* article — Updated
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program *MLN Matters®* article— Revised
- Transition to New Medicare Numbers and Cards Fact Sheet — Revised
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Revised
- Remittance Advice Information: An Overview Booklet — Reminder
- SNF Billing Reference Booklet — Reminder
- Items and Services Not Covered under Medicare Booklet — Reminder
- Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Reminder

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MLN Connects® for November 16, 2017

MLN Connects® for November 16, 2017
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News & Announcements

- New Medicare Card: New Webpage Information
- CAHs: Deadline to Apply for a Hardship Exception is November 30
- Virtual Group for MIPS in 2018: Apply by December 31
- QMB Remittance Advice Issue
- IRF/LTCH Quality Measure Reports: Measures Added
- Hospice Quality Reporting Program: Quarterly Update
- Physician Compare: How to Update Your Listing
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Provider Compliance

- Evaluation and Management: Correct Coding — Reminder

Upcoming Events

- Quality Payment Program Year 2 Final Rule Call — November 30
- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- National Partnership to Improve Dementia Care and QAPI Call — December 14

Medicare Learning Network Publications & Multimedia

- Hospital Call: Audio Recording and Transcript — New
- Medicare and Medicaid Basics Booklet — Revised
- Looking for Educational Materials?

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First Coast Service Options Phone Numbers

***(Note:** Specific geographic contact information is noted when phone numbers and addresses are different for providers in Florida, U.S. Virgin Islands or Puerto Rico.)*

Customer service
Monday to Friday
8:00 a.m. to 4:00 p.m
888-664-4112 (FL/USVI)
877-908-8433 (Puerto Rico)
877-660-1759 (TDD-FL/USVI)
888-216-8261 (TDD-Puerto Rico)

Electronic data interchange
888-670-0940 (FL/USVI)
888-875-9779 (Puerto Rico)

Interactive Voice Response
877-602-8816

Provider education/outreach
Event registration hotline
904-791-8103

Overpayments
904-791-8123

SPOT Help Desk
FCSOSPOTHelp@fcso.com
855-416-4199

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Medicare EDI
Electronic claim filing
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

Fraud and abuse
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

FOIA requests
Provider audit/reimbursement
(relative to cost reports and audits)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

General Inquiries
Online Form (Click here)
Email: *AskFloridaA@fcso.com*

Local coverage determinations
Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, auto accident settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections and debt recovery
Repayment, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Credit balance reports
First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

Post-pay medical review
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

Redetermination
Florida:
Medicare Part A Redetermination/Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

Redetermination (cont'd)

U.S. Virgin Islands:

First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Special delivery/courier services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

DME regional carrier (DMERC)
DME, orthotic, prosthetic device, take-home supply, oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare
Palmetto GBA
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health/hospice intermediary
Palmetto GBA
Medicare Part A
34650 US HWY 19N
Palm Harbor, FL 34684

Contact CMS

Centers for Medicare & Medicaid Services (CMS)
(https://www.cms.gov/)

Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations

ROATLFM@CMS.HHS.GOV

Office of Inspector General (OIG)
Medicare fraud hotline
800-HHS-TIPS (800-447-8477)

Beneficiary customer service
1-800-MEDICARE (1-800-633-4227)

Hearing and speech impaired (TDD)
1-800-754-7820