Medicare A CONNECTION
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
January 2018

In this issue

2018 Medicare travel allowance for collection of specimens

Provider type affected

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

What you need to know

Change request (CR) 10448 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for 2018. Make sure your billing staff is aware of these changes.

Background

Medicare Part B allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act (the Act). Payment for these services is made based on the clinical laboratory fee schedule (CLFS).

The travel codes allow for payment either on a per mileage basis for code P9603 or on a flat rate per trip basis for P9604. Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. Your MAC has the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the MAC.

The per mile travel allowance (P9603) is to be used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

See **TRAVEL**, page 17

Contents

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

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

How unsolicited/voluntary refunds are handled

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable). Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks. Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative

remedies arising from or relating to these or any other claims.

Source: *CMS Pub. 100-06, Chapter 5, Section 410.10*

2018 'Medicare Part B Participating Physician and Supplier Directory'

The *Medicare Part B Participating Physician and Supplier Directory* (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing will be available no later than January 30 on the First Coast Medicare provider website at *https://medicare.fcso.com/MEDPARD/*.

Source: Pub 100-04, Transmittal 3917, CR 10351

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.

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.

Revisions to LCD

Controlled substance monitoring and drugs of abuse testing – revision to the Part A and Part B LCD

LCD ID number: L36393 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for controlled substance monitoring and drugs of abuse testing was revised to remove *Current Procedural Terminology* (CPT®) codes 80159, 80171, 80173, 80183, 80184, 83992, and 84999 from the "CPT®/ HCPCS Codes" section of the LCD since they represent drug testing of therapeutic intent. The focus of the LCD is on drugs of abuse testing and not on therapeutic effect of drugs.

Effective date

This LCD revision is effective for services rendered **on or after January 25, 2018.** 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*.

Duplex scan of lower extremity arteries – revision to the Part A and Part B LCD

LCD ID number: L33667 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for duplex scan of lower extremity arteries, it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after January 9, 2018.** 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*.

Hemophilia clotting factors – revision to the Part A and Part B LCD

LCD ID number: L33684 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10385 (January 2018 integrated outpatient code editor [I/OCE]), the local coverage determination (LCD) for hemophilia clotting factors was revised to reflect that Healthcare Common Procedure Coding System (HCPCS) code J7191 was changed from "Part A and Part B" to "Part B only" in the "CPT®/HCPCS codes" section of the LCD as this code has a Part A status indicator "E2" (Not paid by Medicare when submitted on outpatient claims). Also, HCPCS code J7191 was removed from "Group 1 Paragraph:" under "ICD-10 Codes that Support Medical Necessity" section of the LCD and put in its own group.

Effective date

This LCD revision is effective for services rendered **on or after January 1, 2018.** 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*.

Hepatitis B surface antibody and surface antigen – revision to the Part A and Part B LCD

LCD ID number: L34003 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for hepatitis B surface antibody and surface antigen, it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after January 9, 2018.** 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*.

Luteinizing hormone-releasing hormone (LHRH) analogs – revision to the Part A and Part B LCD

LCD ID number: L33685 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request 10385 (January 2018 Integrated Outpatient Code Editor [I/OCE]), the local coverage determination (LCD) for luteinizing hormone-releasing hormone (LHRH) analogs was revised to reflect that Healthcare Common Procedure Coding System (HCPCS) code J9219 was changed to indicate "Part B only" in the "CPT®/HCPCS codes" section of the LCD as this code has a Part A status indicator "E2" (Not paid by Medicare when submitted on outpatient claims). In addition, the procedure codes in the "CPT®/HCPCS Codes" section of the LCD were put in groups to be consistent with the groups in the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

The LCD revision related to HCPCS code J9219 is effective for services rendered **on or after January 1, 2018.** The LCD revision related to consistency in the groups is effective for claims processed **on or after January 1, 2018.** 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*.

Magnetic resonance angiography (MRA) – revision to the Part A and Part B LCD

LCD ID number: L34372 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for magnetic resonance angiography (MRA), it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after January 9, 2018.** 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*.

Molecular pathology procedures for human leukocyte antigen (HLA) typing – revision to the Part A and Part B LCD

LCD ID number: L34518 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for molecular pathology procedures for human leukocyte antigen (HLA) typing, it was determined that some of the italicized language in the "Documentation Requirements" section of the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after January 9, 2018.** 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*.

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Monitored anesthesia care (MAC) for certain interventional pain management services – revision to the Part A and Part B LCD

LCD ID number: L33595 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for monitored anesthesia care (MAC) for certain interventional pain management services, it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after January 9, 2018.** 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*.

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

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

Based on change request 10236 (October 2017 Update of the Hospital Outpatient Prospective Payment System [OPPS]), the local coverage determination (LCD) for noncovered services was revised to move procedure code 0421T from "CPT®/HCPCS Codes – Group 3 Codes:" under the subtitle "Procedures for Part B only" section of the LCD to "CPT®/HCPCS Codes – Group 1 Codes:" under the subtitle "Procedures for Part A and Part B" section of the LCD with the symbol "++" to indicate it is covered if the beneficiary is enrolled in an approved category B investigational device exemption (IDE) study.

Effective date

This LCD revision is effective for claims processed **on or after January 1, 2018**, for services rendered **on or after June 5, 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*.

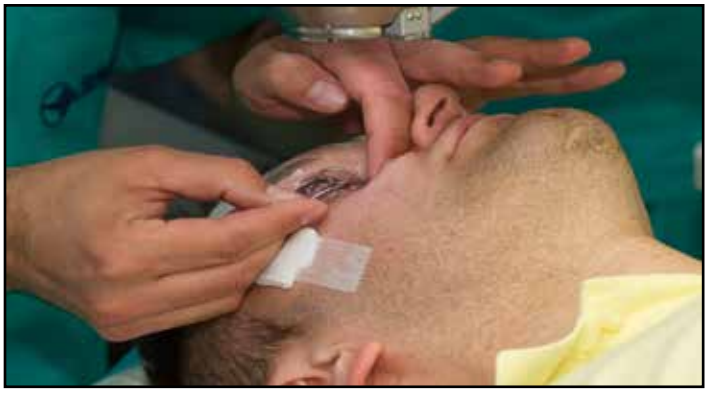
Noncovered services (procedure codes 0449T and 0450T) – revision to the Part A and Part B LCD

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

The noncovered services local coverage article for the sources of information and basis for decision (A52928) was updated to include multiple published sources from reconsideration requests received in 2017 for *Current Procedural Terminology* (CPT®) codes 0449T and 0450T (insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space). Additionally, the noncovered services local coverage determination (LCD) revision history was updated; however, the content of the LCD was not revised in response to the reconsideration requests.

Effective date

This local coverage article revision is effective for services rendered **on or after January 18, 2018**. 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*.

Noncovered procedures - endoscopic treatment of gastroesophageal reflux disease (GERD) – revision to the Part A and Part B LCD

LCD ID number: L33296 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the LCD for noncovered procedures - endoscopic treatment of gastroesophageal reflux disease (GERD) was revised to remove *Current Procedural Terminology* (CPT®) code 43210 from the “CPT®/HCPCS Codes” section of the LCD. Also, language related to “Esophyx” was removed from the “Limitations of Coverage” section of the LCD. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated with eight full text published sources from this reconsideration request for CPT® code 43210 for the Esophyx® system for the treatment of GERD.

Effective date

This LCD revision is effective for services rendered **on or after January 25, 2018.** 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 “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*.

Non-invasive physiologic studies of upper or lower extremity arteries – revision to the Part A and Part B LCD

LCD ID number: L33696 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for non-invasive physiologic studies of upper or lower extremity arteries, it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after January 9, 2018.** 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*.

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

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

The local coverage determination (LCD) for screening and diagnostic mammography was revised to add ICD-10-CM diagnosis codes N63.11-N63.14, N63.21-N63.24, N63.31, N63.32, N63.41, and N63.42 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes 77065, 77066, and G0279.

Effective date

This LCD revision is effective for claims processed **on or after December 29, 2017**, 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, *click here*.

Total calcium – revision to the Part A and Part B LCD

LCD ID number: L34031 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for total calcium, it was determined that some of the italicized language in the "Utilization Guidelines" section of the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after January 9, 2018.** 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*.

Transcranial magnetic stimulation for major depressive disorder – revision to the Part A and Part B LCD

LCD ID number: L34522 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for transcranial magnetic stimulation for major depressive disorder, it was determined that some of the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after January 9, 2018.** 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*.

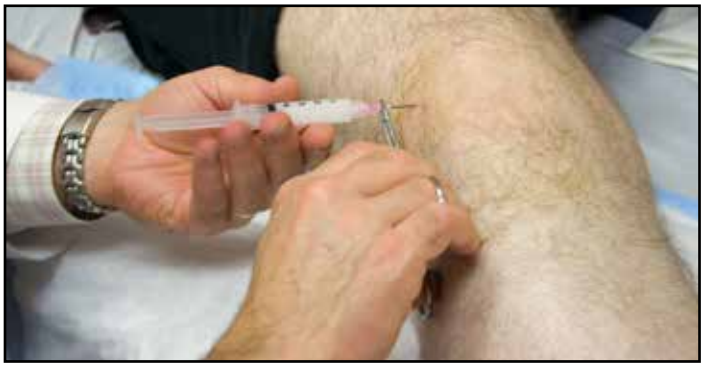
Viscosupplementation therapy for knee – revision to the Part A and Part B LCD

LCD ID number: L33767 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10385 (January 2018 Integrated Outpatient Code Editor [I/OCE]), the local coverage determination (LCD) for viscosupplementation therapy for knee was revised to add Healthcare Common Procedure Coding System (HCPCS) code J7320 to the "CPT®/HCPCS Codes" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD for Part A as the status indicator changed from "E2" (Not paid by Medicare when submitted on outpatient claims) to "K" (Paid under OPPS, separate APC payment).

Effective date

This LCD revision is effective for services rendered **on or after January 1, 2018.** 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*.

Additional Information

Susceptibility studies – revision to the Part A and Part B LCD "coding guidelines"

LCD ID number: L33755 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for susceptibility studies "coding guidelines" were revised to clarify that the diagnosis codes listed in national coverage determination (NCD) 190.12 for *Current Procedural Terminology* (CPT®) codes 87086 and 87088 are also allowed for susceptibility studies (CPT® codes 87181-87190).

Effective date

This revision to the "coding guidelines" is effective for claims processed **on or after December 19, 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*.

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

Note**: This article was revised December 22, 2017, to reflect a revised change request (CR) 10238 issued December 22. In the article, a reference to a discharge date in the last paragraph of the "Background" section is changed to say admission/from date. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information remains the same. This information was previously published in the November 2017 Medicare A Connection, page 17.* ***Note: Editorial corrections made May 23, 2018, to the related CR release date, transmittal number, and link to CR. Also, corrected "Background" section to say admission/from date.

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/from 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/R3943CP.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
December 22,2017	The article was revised to reflect a revised CR 10238 issued December 22. In the article, a reference to a discharge date in the last paragraph of the *Background* section is changed to say admission/from date. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information remains the same.
October 27, 2017	Initial article released.

MLN Matters® Number: MM10238
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3943CP
Related Change Request (CR) Number: 10238
Effective Date: April 1, 2015
Implementation Date: April 2, 2018

Implementation of the transitional drug add-on payment adjustment for ESRD drugs

Note: *This article was revised December 29 to add the section titled "Oral or Other Forms of Injectable Drugs and Biologicals" under "Background" and January 10 to reflect the revised CR 10065, which provide more descriptive examples for Parsabiv and Sensipar. In addition, the CR release date, transmittal number, and the web address for accessing the CR were revised. All other information remains the same. This information was previously published in the August 2017 Medicare A Connection, page 11.* ***Note: Editorial corrections made May 23, 2018, to related CR release date and transmittal number.***

Provider types affected

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

Provider action needed

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

Background

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

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

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

Transitional drug add-on payment adjustment

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

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

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

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

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

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

Parsabiv example

Patient is prescribed 5mg three times per week with a payment limit of $3.50 per 0.1 mg.

1/1/2018 HCPCS J0606, 50 units
1/1/2018 REV 821

1/3/2018 HCPCS J0606, 50 units
1/3/2018 REV 821

See **ESRD**, page 14

ESRD

from page 13

1/5/2018 HCPCS J0606, 50 units
1/5/2018 REV 821

1/8/2018 HCPCS J0606, 50 units
1/8/2018 REV 821

1/10/2018 HCPCS J0606, 50 units
1/10/2018 REV 821

1/12/2018 HCPCS J0606, 50 units
1/12/2018 REV 821

1/15/2018 HCPCS J0606, 50 units
1/15/2018 REV 821

1/17/2018 HCPCS J0606, 50 units
1/17/2018 REV 821

1/19/2018 HCPCS J0606, 50 units
1/19/2018 REV 821

1/22/2018 HCPCS J0606, 50 units
1/22/2018 REV 821

1/24/2018 HCPCS J0606, 50 units
1/24/2018 REV 821

1/26/2018 HCPCS J0606, 50 units
1/26/2018 REV 821

1/29/2018 HCPCS J0606, 50 units
1/29/2018 REV 821

1/31/2018 HCPCS J0606, 50 units
1/31/2018 REV 821

Q8 is assigned $2450 ((50 * 3.50) * 14 = $2450)
Number of dialysis treatments for month = 14
Adjusted ESRD PPS base rate = $250.00
QIP reduction = 0.985

Cost of TDAPA drug/ number of dialysis treatments for the month = TDAPA payment per treatment

$2450/ 14 = $175

Final payment rate = (Adjusted ESRD PPS base rate + TDAPA payment per treatment) * QIP reduction

$418.63 = ($250.00 + $175) * 0.985

$418.63 = $425 * 0.985

The final per treatment payment rate is $418.63

Sensipar example

Patient is prescribed 1-30mg tablet per day January 10, 2018 with a payment limit of $1.00 per 1 mg.

1/1/2018 REV 821

1/3/2018 REV 821

1/5/2018 REV 821

1/8/2018 REV 821

1/10/2018 HCPCS J0604, 660 units

1/10/2018 REV 821

1/12/2018 REV 821

1/15/2018 REV 821

1/17/2018 REV 821

1/19/2018 REV 821

1/22/2018 REV 821

1/24/2018 REV 821

1/26/2018 REV 821

1/29/2018 REV 821

1/31/2018 REV 821

Q8 is assigned $660 ((660*1) = $660)
Number of dialysis treatments for month = 14
Adjusted ESRD PPS base rate = $250.00
QIP reduction = 0.985

Cost of TDAPA drug/ number of dialysis treatments for the month = TDAPA payment per treatment

$660/ 14 = $47.14

Final payment rate = (Adjusted ESRD PPS base rate + TDAPA payment per treatment) * QIP reduction

$292.68 = ($250.00 + $47.14) * 0.985

$292.68 = $297.14 * 0.985

The final per treatment payment rate is $292.68

Oral or other forms of injectable drugs and biologicals

ESRD facilities are responsible for furnishing renal dialysis services either directly or under arrangement. The one exception to this policy is oral-only drugs and biologicals that are not paid under the ESRD PPS until January 1, 2025.

CMS recognizes that ESRD facilities may have unique circumstances with regard to furnishing oral and other forms of injectable drugs and biologicals when the medication cannot be administered in the ESRD facility. For example, a pharmacy may, under arrangement with the ESRD facility, dispense the medication and provide the patient with instructions on how to self-administer the drug. In this situation, the ESRD facility is responsible for developing contractual arrangements with pharmacies and ensuring that appropriate delivery and billing of the drug is completed in accordance with the beneficiary's plan of care.

CMS Pub. 100-02, Chapter 11, Section 20.3.C provides the reporting guidance for oral or other forms of renal dialysis drugs that are filled at the pharmacy or furnished directly by an ESRD facility for home use. ESRD facilities are instructed to report one line item per prescription, but only for the quantity of the drug expected to be taken during the claim billing period, that is, calendar month. ESRD facilities should use the best information they have to determine the amount expected to be taken in a given calendar month, including prescription fill information from the pharmacy and the patient's plan of care (80 FR 37838).

ESRD facility claims include only the items and services used during the calendar month. CMS does not expect facilities to physically administer the drug to the patient, however, CMS does expect facilities to be aware of the

See **ESRD**, page 15

ESRD

from page 14

patient's plan of care and know the medications the patient was instructed to take for the claim's time period, and ensure the claim reflects that plan of care.

With the implementation of TDAPA, facilities are now responsible for reporting an oral calcimimetic (J0604) on the ESRD claim. The ESRD PPS is built and operationalized around the monthly reporting of items and services that are furnished. However, we recognize that continuity of therapy may be unpredictable. For example, beneficiaries can be hospitalized, switch facilities, or change dosages all within the same calendar month. CMS recognizes that these situations may be beyond the control of the ESRD facility and that they can impact payment. ESRD facilities will need to determine the most appropriate way to furnish drugs and biologicals that ensures patients receive their required medications, while mitigating the facilities' risk for drug costs.

Again, with regard to reporting for the oral calcimimetic (J0604), CMS expects that ESRD facilities will report the quantity of the drug expected to be taken during the calendar month using the best information available as discussed above. CMS does not expect the date of the line on the claim for the oral calcimimetic to correspond to a treatment date or the specific day that the patient received the supply of medication, however, the facility's recordkeeping (for example, the patient's medical record) should be consistent with the claim.

CMS expects all providers and suppliers to supply and administer all patient drugs and biologicals in a clinically approved, efficient and economical manner. CMS will closely monitor the utilization of renal dialysis services and the use of TDAPA to analyze trends, behaviors and require appropriate corrective action when necessary.

Additional information

The official instruction, CR 10065, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1999OTN.pdf*.

The 2016 ESRD PPS final rule is available at *https://www.gpo.gov/fdsys/pkg/FR-2015-11-06/pdf/2015-27928.pdf*.

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

Document history

Date of change	Description
January 10, 2018	The article was revised to provide more descriptive examples in the *Background* section for Parsabiv and Sensipar. The CR release date, transmittal number and the web address for accessing the CR were revised also. All other information remains the same.
December 29, 2017	The article was revised December 29, 2017, in order to add the section titled *Oral or other forms of injectable drugs and biologicals* in the *Background* section.
August 9, 2017	Initial article released

MLN Matters® Number: MM10065
Related CR Release Date: January 10, 2018
Related CR Transmittal Number: R1999OTN
Related Change Request (CR) Number: CR 10065
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Suppression of the standard paper remittance advice in 45 days if also receiving ERA

***Note**: This article was revised December 29, 2017, to reflect the revised change request (CR) 10151 issued December 28, 2017. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same. This information was previously published in the August 2017 Medicare A Connection, page 1.*

Provider type affected

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

Provider action needed

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

Background

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

Beginning February 14, 2018, the SSMs shall suppress the delivery of SPR to the MACs EDI enrolled providers/suppliers who are also receiving both the ERA and SPR. In rare situations (such as natural or man-made disasters) exceptions to this policy may be allowed at the discretion of the Centers for Medicare & Medicaid Services (CMS). MACs will not send a SPR/hard copy version to a particular provider/supplier unless this requirement causes hardship and CMS has approved a waiver requested by your MAC.

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

Additional information

The official instruction, CR 10151, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1994OTN.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
December 29, 2017	This article was revised to reflect the revised CR 10151 issued December 28, 2017. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same.
December 22, 2017	This article was revised to reflect the revised CR 10151 issued December 21, 2017. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same.
August 7, 2017	Initial article released.

MLN Matters® Number: MM10151 *Revised*
Related CR Release Date: December 28, 2017
Related CR Transmittal: R1994OTN
Related Change Request (CR) Number: 10151
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

January 2018 update of the hospital outpatient prospective payment system

Provider type affected

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

Provider action needed

Change request (CR) 10417 describes changes to the OPPS to be implemented in the January 2018 update. Make sure your billing staffs are aware of these changes.

Background

CR 10417 describes changes to and billing instructions for various payment policies implemented in the January 2018 OPPS update. The January 2018 integrated outpatient code editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in this CR.

The January 2018 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming January 2018 I/OCE CR 10385. Once the I/OCE CR is issued, a related *MLN Matters*® article will be available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10385.pdf*.

Key changes to and billing instructions for various payment policies implemented in the January 2018 OPPS update are as follows:

New device pass-through categories

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two (2), but not more than three (3), years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that the Centers for Medicare & Medicaid Services (CMS) create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

Effective January 1, 2018, there are no device categories eligible for pass-through payment. However, an existing device described by HCPCS code C2623 (*Catheter, transluminal angioplasty, drug coated, non-laser*) was approved on August 25, 2017, by the Food and Drug Administration (FDA) for a new indication, specifically the treatment of patients with dysfunctional arteriovenous (AV) fistulae.

Accordingly, in this January 2018 update, devices described by HCPCS code C2623 are eligible for pass through status retroactive to August 25, 2017, when the device is billed with *Current Procedural Terminology* (CPT®) code 36902 (*Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including*

See **OPPS**, page 18

TRAVEL

from page 1

The allowance per mile was computed using the Federal mileage rate of $0.545 per mile plus an additional $0.45 per mile to cover the technician's time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $1.00 per mile if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the CLFS, as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

The per flat-rate trip basis travel allowance (P9604) for 2018 is $10.00.

Additional information

The official instruction, MM10448, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3942CP.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
January 2, 2018	Initial article released.

MLN Matters® Number: MM10448
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3942CP
Related Change Request (CR) Number: 10448
Effective Date: January 1, 2018
Implementation Date: January 22, 2018

OPPS

from page 17

the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty) or CPT® code 36903 *(Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment)*. This device pass through status will be applied retroactively from August 25, 2017, through December 31, 2017.

Refer to *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html* for the most current device pass-through information.

Transitional pass-through payments for designated devices

Certain designated new devices are assigned to ambulatory payment classifications (APCs) and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for device(s) used in the procedure. OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device.

Refer to *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files-Items/2018-Annual-Policy-Files.html* for the most current OPPS HCPCS offset file.

Device offset from payment for device category

Section 1833(t)(6)(D)(ii) of the Act requires CMS to deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount. With respect to device code C2623, CMS has previously determined that the costs associated with C2623 are not reflected in the APC payment amount. Therefore, CMS is not applying a device offset to the retroactive pass-through payments for C2623. Retroactive pass-through payments for August 25, 2017, through December 31, 2017, will only apply when HCPCS code C2623 is billed with CPT® code 36902 or CPT® code 36903. The device/procedure offset pair requirements for HCPCS code C2623 listed in change request 9553, Transmittal 3483 are no longer applicable effective January 1, 2018.

New separately payable procedure code

Effective January 1, 2018, new HCPCS code C9748 has been created, as described in Table 1.

Table 1. — New separately payable procedure code, effective January 1, 2018

Code	Short descriptor	Long descriptor	Jan 2018 OPPS SI	Jan 2018 OPPS APC
C9748	Prostatic rf water vapor tx	Trans-urethral destruction of prostate tissue; by radio-frequency water vapor (steam) thermal therapy	J1	5373

Argus retinal prosthesis add-on code (C1842)

Effective January 1, 2017, CMS created HCPCS code C1842 (Retinal prosthesis, includes all internal and external components; add-on to C1841) and assigned it the status indicator (SI) of "N." HCPCS code C1842 was created to resolve a claim processing issue for ambulatory surgical centers (ASCs) and should not be reported on institutional claims by hospital outpatient department providers. HCPCS code C1842 is included in the 2018 annual HCPCS file.

Changes to new technology APCs 1901–1908

Effective January 1, 2018, two additional new technology APCs (1907 and 1908) are created. In addition, the payment ranges for APCs 1901 – 1906 have been changed. All changes are documented in Table 2.

Table 2. — 2018 additional new technology APC groups

2018 APC	2018 APC title	2018 SI	Updated or new APC
1901	New technology - level 49 ($100,001-$115,000)	S	Updated
1902	New technology - level 49 ($100,001-$115,000)	T	Updated
1903	New technology - level 50 ($115,001-$130,000)	S	Updated
1904	New technology - level 50 ($115,001-$130,000)	T	Updated
1905	New technology - level 51 ($130,001-$145,000)	S	Updated
1906	New technology - level 51 ($130,001-$145,000)	T	Updated
1907	New technology - level 52 ($145,001-$160,000)	S	New

See **OPPS**, page 19

OPPS

from page 18

2018 APC	2018 APC title	2018 SI	Updated or new APC
1908	New technology - level 52 ($145,001-$160,000)	T	New

Services eligible for new technology APC assignment and payments

Under OPPS, services eligible for payment through new technology APCs are those codes that are assigned to the series of new technology APCs published in Addendum A of the latest OPPS update. OPPS considers any HCPCS code assigned to the APCs below to be a "new technology procedure or service." As of January 1, 2018, the range of new technology APCs include:

- APCs 1491 through 1500
- APCs 1502 through 1537
- APCs 1539 through 1585,
- APCs 1589 through 1599
- APCs 1901 through 1908

The application for consideration as a new technology procedure or service is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html*. At that website, under the *Downloads* section, refer to the document, titled *for a new technology ambulatory payment classification (APC) designation under the hospital outpatient prospective payment system (OPPS)* for information on the requirements for submitting an application. The list of HCPCS codes and payment rates assigned to new technology APCs are in Addendum B of the latest OPPS update regulation each year at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Payment changes for X-rays taken using film and computed radiography technology

On December 18, 2015, the Consolidated Appropriations Act of 2016 was signed into law (Public Law 114-113). Section 502 of the Consolidated Appropriations Act requires that Medicare implement the following provisions under the hospital OPPS for the technical component of imaging services:

- Reduce payment by 20 percent for an X-ray taken using film, beginning January 1, 2017, and
- Reduce payment by seven percent from January 1, 2018 through December 31, 2022, and
- Thereafter to 10 percent, beginning January 1, 2023,

For an imaging service that is an X-ray taken using computed radiography technology.

In response to these provisions, CMS established modifiers "FX," effective January 1, 2017, and "FY," effective January 1, 2018. Below is additional information related to these modifiers. CMS notes that Section 502(b) of Division O, Title V of the Consolidated Appropriations Act of 2016 amended Section 1833(t)(16) of the Act by adding new subparagraph (F).

Payment modifier for X-ray taken using film, effective January 1, 2017

Consistent with the requirements set forth in Section 1833(t)(16)(F)(i) and in accordance with provisions allowed under Section 1833(t)(16)(F)(iv) of the Act, CMS established modifier "FX" (*X-ray taken using film*) to identify imaging services that are X-rays taken using film. As stated in the 2017 OPPS/ASC final rule with comment period (81 FR 79729 through 79730) and in the January 2017 update of the OPPS (change request 9930, Transmittal 3685, dated December 22, 2016), hospitals are required to use this modifier to report imaging services that are X-rays taken using film, effective January 1, 2017.

The use of the FX modifier is applicable to all imaging services that are X-rays taken using film and results in a payment reduction of 20 percent, beginning January 1, 2017. All imaging services are listed in the OPPS Addendum B.

Payment modifier for X-ray taken using computed radiography technology, effective January 1, 2018

Consistent with the requirements set forth in Section 1833(t)(16)(F)(ii) and in accordance with provisions allowed under Section 1833(t)(16)(F)(iv) of the Act, CMS established modifier FY (*X-ray taken using computed radiography technology/cassette-based imaging*) to identify an imaging service that is an X-ray taken using computed radiography technology. Effective January 1, 2018, hospitals are required to use this modifier to report imaging services that are X-rays taken using computed radiography technology.

The use of this modifier results in a payment reduction of 7 percent from January 1, 2018, through December 31, 2022, and thereafter to 10 percent beginning January 1, 2023, for imaging services that are X-rays taken using computed radiography technology/cassette-based imaging. All imaging services are listed in the OPPS Addendum B.

Deletion of modifier CP

Modifier CP became effective in 2016 and was used to identify adjunctive services on a claim related to a procedure assigned to a comprehensive ambulatory payment classification (C-APC) procedure. The use of the modifier was required for 2016 and 2017 and the data collection period for this modifier was set to conclude December 31, 2017. Accordingly, for 2018, CMS is deleting modifier CP and discontinuing its required use.

Also, for 2018, for the C-APC for stereotactic radio surgery (SRS), specifically, C-APC 5627 (Level 7 radiation therapy), CMS will continue to make separate payments for the 10 planning and preparation services adjunctive to

See **OPPS**, page 20

OPPS

from page 19

the delivery of the SRS treatment using either the Cobalt-60-based or LINAC-based technology when furnished to a beneficiary within 30 days of the SRS treatment. The 10 planning and preparation codes listed in Table 3 will be paid according to their assigned SI when furnished within 30 days of SRS treatment delivery.

Table 3. – Excluded planning and preparation CPT® codes

CPT® code	2018 short descriptor	2018 SI
70551	MRI brain stem w/o dye	Q3
70552	MRI brain stem w/dye	Q3
70553	MRI brain stem w/o & w/dye	Q3
77011	Ct scan for localization	N
77014	Ct scan for therapy guide	N
77280	Set radiation therapy field	S
77285	Set radiation therapy field	S
77290	Set radiation therapy field	S
77295	3-d radiotherapy plan	S
77336	Radiation physics consult	S

Changes to the inpatient-only (IPO list)

The Medicare inpatient-only (IPO) list includes procedures that are typically only provided in the inpatient setting and therefore are not paid under the OPPS. For 2018, CMS is removing total knee arthroplasty (TKA) from the IPO list as well as five other procedures. CMS is also adding one procedure to the IPO list. The changes to the IPO list for 2018 are included in Table 4.

Table 4. — Changes to the inpatient only list for 2018

2018 CPT® code	2018 long descriptor	Status	2018 OPPS APC assign-ment	2018 OPPS SI
27447	Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty)	Removed	5115	J1
43282	Laparoscopy, surgical, repair of para-esophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Removed	5362	J1
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	Removed	5303	J1
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	Removed	5361	J1
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	Removed	5303	J1

See **OPPS**, page 21

OPPS

from page 20

2018 CPT® code	2018 long descriptor	Status	2018 OPPS APC assign-ment	2018 OPPS SI
55866	Laparoscopy, surgical	Removed	5362	J1
92941	Percutaneous transluminal	Added	N/A	C

Revisions to the laboratory date of service (DOS) policy

a. Laboratory test/service performed by an independent laboratory

In the 2018 OPPS/ASC final rule (82 FR 52533-52540), CMS discussed an additional exception to current laboratory DOS regulations at *42 Code of Federal Regulations* (CFR) 414.510. This new exception to the laboratory DOS policy permits independent laboratories to bill Medicare directly for molecular pathology tests and advanced diagnostic laboratory tests (ADLTs), which are excluded from the OPPS packaging policy, if the specimen was collected from a hospital outpatient during a hospital outpatient encounter and the test was performed following the patient's discharge from the hospital outpatient department.

Consequently, hospital outpatient departments (HOPDs) should no longer bill Medicare for molecular pathology tests and ADLTs performed by independent laboratories following the patient's discharge from the HOPD, and independent laboratories will no longer have to seek payment from the HOPD for these tests, if all of the conditions are met.

Note there are no current codes designated as ADLTs; however, molecular pathology codes are currently assigned to OPPS SI "A" to indicate that they are not paid under the OPPS, but may be paid under a different Medicare payment system.

b. Laboratory test/service performed by a hospital laboratory

For a molecular pathology test or ADLT test performed by a hospital laboratory, refer to the *Medicare Claims Processing Manual*, Chapter 16, Laboratory Services, Section 50.3, Hospitals.

OPPS status indicator updates for clinical laboratory fee schedule (CLFS) molecular pathology tests and advanced diagnostic laboratory tests (ADLTs)

Under the OPPS, Medicare conditionally packages laboratory tests and only pays separately for certain types of laboratory tests. Molecular pathology tests and ADLTs are paid separately at the CLFS rate rather than the OPPS. The current list of molecular pathology tests is available in the OPPS Addendum B (*https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*) and are identified with status indicator "A."

However, for the January 2018 OPPS update, there are no laboratory tests currently designated by CMS as ADLTs under the CLFS. As stated in the 2017 OPPS/ASC final rule with comment period (81 FR 79594), CMS will assign SI "A" (*Not paid under OPPS. Paid by Medicare Administrative Contractors (MACs) under a fee schedule or payment system other than OPPS)* to ADLTs once a laboratory test has been granted ADLT status under the CLFS.

Prior to ADLT designation, applicants must submit an application to CMS requesting ADLT status for a laboratory test. Once a test is designated by CMS as an ADLT under paragraph (1) of the definition of advanced diagnostic laboratory test in 42 CFR 414.502, CMS will update the OPPS Addendum B on a quarterly basis to reflect the appropriate SI assignment.

Billing instructions for 340B-acquired drugs

As finalized in the CY 2018 OPPS/ASC final rule with comment period, separately payable Part B drugs (assigned SI "K"), other than vaccines (assigned SI "L" or "M") and drugs on pass-through payment status (assigned SI "G") that are acquired through the 340B Program or through the 340B prime vendor program, will be paid at the average sales price (ASP) minus 22.5 percent, when billed by a hospital paid under the OPPS that is not excepted from the payment adjustment.

Hospital types that are excepted from the 340B payment policy in 2018 include rural sole community hospitals (SCHs), children's hospitals, and prospective payment system (PPS)-exempt cancer hospitals. These excepted hospitals will continue to receive ASP + six percent payment for separately payable drugs.

Medicare will continue to pay separately payable drugs that were not acquired under the 340B program at ASP + six percent.

In addition, effective January 1, 2018, hospitals paid under the OPPS that are not excepted from the 340B drug payment policy for 2018 are required to report modifier "JG" on the same claim line as the drug HCPCS code to identify a 340B-acquired drug. Since rural SCHs, children's hospitals and PPS-exempt cancer hospitals are excepted from the 340B payment adjustment in 2018, these hospitals will report informational modifier "TB" for 340B-acquired drugs, and will continue to be paid at the ASP + six percent.

The 340B modifiers and their descriptors are listed in Table 5.

Table 5 – Modifiers for 340B-acquired drugs

Two-digit HCPCS modifier	Short descriptor	Long descriptor	Effective date
JG	340B acquired drug	Drug or biological acquired with 340B drug pricing program discount	1/1/18

See **OPPS**, page 22

OPPS

from page 21

Two-digit HCPCS modifier	Short descriptor	Long descriptor	Effective date
TB	Tracking 340B acquired drug	Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes	

Drugs, biologicals, and radiopharmaceuticals

a. New 2018 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For 2018, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available.

These new codes are listed in Table 6.

Table 6 – New 2018 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

2018 HCPCS code	2018 long descriptor	2018 SI	2018 APC
C9014	Injection, cerliponase alfa, 1 mg	G	9014
C9015	Injection, c-1 esterase inhibitor (human), Haegarda, 10 units	G	9015
C9016	Injection, triptorelin extended release, 3.75 mg	G	9016
C9024	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	G	9302
C9028	Injection, inotuzumab ozogamicin, 0.1 mg	G	9028
C9029	Injection, guselkumab, 1 mg	G	9029
J0604	Cinacalcet, oral, 1 mg, (for ESRD on dialysis)	B	N/A
J0606	Injection, etelcalcetide, 0.1 mg	K	9031
J1555	Injection, immune globulin (cuvitru), 100 mg	K	9034
J7211	Injection, factor viii, (antihemophilic factor, recombinant), (kovaltry), 1 i.u.	K	9075
J7345	Aminolevulinic acid hcl for topical administration, 10% gel, 10 mg	G	9301
J9203	Injection, gemtuzumab ozogamicin, 0.1 mg	G	9495
Q2040	Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	K	9081
Q4176	Neopatch, per square centimeter	N	N/A
Q4177	Floweramnioflo, 0.1 cc	N	N/A
Q4178	Floweramniopatch, per square centimeter	N	N/A
Q4179	Flowerderm, per square centimeter	N	N/A
Q4180	Revita, per square centimeter	N	N/A
Q4181	Amnio wound, per square centimeter	N	N/A
Q4182	Transcyte, per square centimeter	N	N/A

b. Other changes to 2018 HCPCS and CPT® codes for certain drugs, biologicals, and radiopharmaceuticals

Many HCPCS and CPT® codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in its HCPCS and CPT® code descriptors that will be effective in 2018. In addition, several temporary HCPCS C-codes have been deleted, effective December 31, 2017, and replaced with permanent HCPCS codes effective 2018. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active 2018 HCPCS and CPT® codes.

Table 7 notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT® code, their long descriptor, or both. Each product's 2017 HCPCS/CPT® code and long descriptor are noted in the two left-hand columns and the 2018 HCPCS/CPT® code and long descriptor are noted in the adjacent right-hand columns.

Table 7 – Other 2018 HCPCS and CPT® code changes for certain drugs, biologicals, and radiopharmaceuticals

2017 code	2017 long descriptor	2018 code	2018 long descriptor
C9490	Injection, bezlotoxumab, 10 mg	J0565	Injection, bezlotoxumab, 10 mg

See **OPPS**, page 23

OPPS

from page 22

2017 code	2017 long descriptor	2018 code	2018 long descriptor
C9484	Injection, eteplirsen, 10 mg	J1428	Injection, eteplirsen, 10 mg
C9486	Injection, granisetron extended release, 0.1 mg	J1627	Injection, granisetron, extended release, 0.1 mg
Q9986	Injection, hydroxy-progesterone caproate (Makena), 10 mg	J1726	Injection, hydroxy-progesterone caproate (Makena), 10 mg
Q9985	Injection, hydroxy-progesterone caproate, not otherwise specified, 10 mg	J1729	Injection, hydroxy-progesterone caproate, not otherwise specified, 10 mg
C9489	Injection, nusinersen, 0.1 mg	J2326	Injection, nusinersen, 0.1 mg
C9494	Injection, ocrelizumab, 1 mg	J2350	Injection, ocrelizumab, 1 mg
Q9989	Ustekinumab, for Intravenous Injection, 1 mg	J3358	Ustekinumab, for Intravenous Injection, 1 mg
C9140	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.	J7210	Injection, factor viii, (antihemophilic factor, recombinant), (Afstyla), 1 i.u.
Q9984	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg	J7296	Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg
C9483	Injection, atezolizumab, 10 mg	J9022	Injection, atezolizumab, 10 mg
C9491	Injection, avelumab, 10 mg	J9023	Injection, avelumab, 10 mg
C9485	Injection, olaratumab, 10 mg	J9285	Injection, olaratumab, 10 mg

c. Drugs and biologicals with payments based on average sales price (ASP), effective January 1, 2018

For 2018, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals that were not acquired through the 340B program is made at a single rate of ASP + six percent (or ASP minus 22.5 percent if acquired under the 340B program), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical.

In 2018, a single payment of ASP + six percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2018, payment rates for many drugs and biologicals have changed from the values published in the 2018 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of 2017. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2018 fiscal intermediary shared system (FISS) release.

CMS is not publishing the updated payment rates in CR 10417 implementing the January 2018 update of the OPPS. However, the updated payment rates effective January 1, 2018, are in the January 2018 update of the OPPS Addendum A and Addendum B at ----https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Adden-dum-A-and-Addendum-B-Updates.html.

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

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

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

e. Biosimilar payment policy

Effective January 1, 2018, the payment rate for biosimilars in the OPPS will generally continue to be the same as the payment rate in the physician office setting, calculated as the ASP of the biosimilar described by the HCPCS code + six percent of the ASP of the reference product. Biosimilars will also be eligible for transitional pass-through payment for which payment will be made at the ASP of the biosimilar described by the HCPCS code + six percent of the ASP of the reference product. A biosimilar that does

See **OPPS**, page 24

OPPS

from page 23

not have pass-through status, but instead has SI of "K," will be paid the ASP of the biosimilar minus 22.5 percent of the ASP of the reference product, effective January 1, 2018.

In addition, effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code with other biosimilars. CMS will issue guidance on coding, including instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers separate from CR 10417. However, until such guidance is released, providers should continue to use applicable existing HCPCS codes and report a biosimilar modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code, but are made by different manufacturers. A list of the biosimilar biological product HCPCS codes and modifiers is available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/Part-B-Biosimilar-Biological-Product-Payment.html*.

Skin substitute procedure edits

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups:

1) High cost skin substitute products, and

2) Low cost skin substitute products for packaging purposes.

Table 8 lists the skin substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable.

Table 8 – Skin substitute assignments to high-cost and low-cost groups for 2018

2018 HCPCS code	2018 short descriptor	2018 SI	2018 high/low assignment
C9363	Integra Meshed Bil Wound Mat	N	High
Q4100	Skin Substitute, NOS	N	Low
Q4101	Apligraf	N	High
Q4102	Oasis Wound Matrix	N	Low
Q4103	Oasis Burn Matrix	N	High
Q4104	Integra bmwd	N	High
Q4105	Integra drt or omnigraft	N	High
Q4106	Dermagraft	N	High
Q4107	GraftJacket	N	High
Q4108	Integra Matrix	N	High
Q4110	Primatrix	N	High
Q4111	Gammagraft	N	Low
Q4115	Alloskin	N	Low
Q4116	Alloderm	N	High
Q4117	Hyalomatrix	N	Low
Q4121	Theraskin	N	High
Q4122	Dermacell	N	High
Q4123	Alloskin	N	High
Q4124	Oasis Tri-layer Wound Matrix	N	Low
Q4126	Memoderm/derma/ tranz/integup	N	High
Q4127	Talymed	N	High
Q4128	Flexhd/Allopatchhd/ Matrixhd	N	High
Q4131	Epifix or epicord	N	High
Q4132	Grafix core, grafixpl core	N	High
Q4133	Grafix prime grafix pl prime	N	High
Q4134	Hmatrix	N	Low
Q4135	Mediskin	N	Low
Q4136	Ezderm	N	Low
Q4137	Amnioexcel or Biodexcel, 1cm	N	High
Q4138	Biodfence dryflex, 1cm	N	High
Q4140	Biodfence 1cm	N	High
Q4141	Alloskin ac, 1cm	N	High
Q4143	Repriza, 1cm	N	High
Q4146	Tensix, 1 cm	N	High
Q4147	Architect ecm px fx 1 sq cm	N	High
Q4148	Neox neox rt, or clarix cord	N	High
Q4150	Allowrap ds or dry 1 sq cm	N	High
Q4151	Amnioband, guardian 1 sq cm	N	High
Q4152	Dermapure 1 square cm	N	High
Q4153	Dermavest, plurivest sq cm	N	High
Q4154	Biovance 1 square cm	N	High
Q4156	Neox 100 or clarix 100	N	High

See **OPPS**, page 25

OPPS

from page 24

2018 HCPCS code	2018 short descriptor	2018 SI	2018 high/low assignment
Q4157	Revitalon 1 square cm	N	High
Q4158	Kerecis omega3, per sq cm	N	High
Q4159	Affinity 1 square cm	N	High
Q4160	NuShield 1 square cm	N	High
Q4161	Bio-Connekt per square cm	N	High
Q4163	Woundex, bioskin, per sq cm	N	High
Q4164	Helicoll, per square cm	N	High
Q4165	Keramatrix, per square cm	N	Low
Q4166	Cytal, per square cm	N	Low
Q4167	Truskin, per square cm	N	Low
Q4169	Artacent wound, per square cm	N	High
Q4170	Cygnus, per square cm	N	Low
Q4172*	Puraply or puraply am	N	High
Q4173	Palingen or palingen xplus	N	High
Q4175	Miroderm	N	High
Q4176*	Neopatch, per square centimeter	N	Low
Q4178*	Floweramniopatch, per sq cm	N	Low
Q4179*	Flowerderm, per square centimeter	N	Low
Q4180*	Revita, per sq cm	N	Low
Q4181*	Amnio wound, per square centimeter	N	Low
Q4182*	Transcyte, per square centimeter	N	Low

* HCPCS codes Q4176, Q4178, Q4179, Q4180, Q4181, and Q4182 were assigned to the low-cost group in 2018 OPPS/ASC final rule with comment period. Pass-through status for HCPCS code Q4172 ended December 31, 2017.

New HCPCS codes for pathogen reduced platelets and pathogen testing for platelets

For the January 2018 update, the HCPCS workgroup deleted HCPCS codes Q9987 and Q9988 for Medicare reporting and replaced the codes with two new HCPCS codes effective January 1, 2018. Specifically, to report the service described by HCPCS code Q9988 based on the code descriptor in effect for July 1, 2017, through December 31, 2017, providers must instead report HCPCS code P9073 (Platelets, pathogen reduced, each unit) instead of HCPCS code Q9988 effective January 1, 2018. Providers reporting the service described by HCPCS code Q9987 based on the code descriptor in effect for July 1, 2017, through December 31, 2017 shall instead report HCPCS code P9100 (Pathogen(s) test for platelets) instead of HCPCS code Q9987 effective January 1, 2018. Note that HCPCS code P9100 should be reported to describe the test used for the detection of bacterial contamination in platelets as well as any other test that may be used to detect pathogen contamination. Table 9 describes blood platelet coding changes that are effective January 1, 2018. The coding changes associated with these codes were also published on the CMS HCPCS quarterly update website effective January 2018, at *https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html*. The payment rates for HCPCS codes P9073 and P9100 can be found in the January 2018 OPPS Addendum B, which is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Table 9. – Blood platelet coding changes effective January 1, 2018

Code	Short descriptor	Long descriptor	Jan 2018 OPPS SI	Jan 2018 OPPS APCS
P9073	Platelets, pathogen reduced	Platelets, pathogen reduced, each unit	R	9536
P9100	Pathogen test for platelets	Pathogen(s) test for platelets	S	1493

Payment adjustment for certain cancer hospitals beginning 2018

For certain cancer hospitals that receive interim monthly payments associated with the cancer hospital adjustment at 42 CFR 419.43(i), Section 16002(b) of the 21st Century Cures Act which requires that, for 2018 and subsequent calendar years, the target payment-to-cost ratio (PCR) that should be used in the calculation of the interim monthly payments and at final cost report settlement is reduced by 0.01. For 2018, the target PCR, after including the reduction required by Section 16002(b), is 0.88.

Section 4011 of the 21st Century Cures Act

Section 4011 of the 21st Century Cures Act created a new subsection (t) in Section 1834 of the Social Security Act that requires CMS to make available to the public a searchable internet website that compares estimated payment and beneficiary liability for an appropriate number of items and services paid under the OPPS and the ASC

See **OPPS**, page 26

OPPS

from page 25

payment system. Consistent with this statute, CMS plans to first make this website available during 2018.

CMS believes that making available a comparison for all services that receive separate payment under both the OPPS and ASC payment system would be most useful to the public with regards to displaying the comparison for an "appropriate number of such items and services." CMS believes that displaying the national unadjusted payments and copayment amounts will allow the user to make a meaningful comparison between the systems for items and services paid under both systems. CMS may consider providing payment and copayment comparisons at the locality or provider level for future years.

Along with the comparison information that CMS will make available to the public in accordance with the requirements of Section 4011, CMS also plans to include a disclaimer statement that notes some of the payment policy differences in each care setting and that notes the limitations of the comparison tool, to provide users with some context for why there might be potential differences. In the case of the OPPS copayments, CMS plans to include an additional indicator where the service is likely to be capped at the Part A inpatient deductible, based on the unadjusted copayments, under the OPPS coinsurance rules.

Changes to OPPS pricer logic

a. Rural SCHs and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in 2018. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13)(B) of the Act, as added by Section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b. New OPPS payment rates and copayment amounts will be effective January 1, 2018. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the 2018 inpatient deductible of $1,340. For most OPPS services, copayments are set at 20 percent of the APC payment rate.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2018. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of the estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. The fixed-dollar threshold for OPPS outlier payments increases in 2018 relative to 2017. The estimated cost of a service must be greater than the APC payment amount plus $4,150 in order to qualify for outlier payments.

e. For outliers for community mental health centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2017. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 5853 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 5853 payment x 3.4))/2.

f. Continuing Medicare's established policy for 2018, the OPPS pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

g. Effective January 1, 2018, CMS is adopting the FY 2018 IPPS post-reclassification wage index values with application of the 2018 out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals as implemented through the pricer logic.

h. Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), a device offset cap will be applied based on the credit amount listed in the "FD" (credit received from the manufacturer for a replaced medical device) value code. The credit amount in value code "FD" which reduces the APC payment for the applicable procedure will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*.

Coverage determinations

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

Additional information

The official instruction, CR 10417, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3941CP.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/*.

See **OPPS**, page 27

January 2018 integrated outpatient code editor specifications version 19.0

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

Change request (CR) 10385 provides the integrated outpatient code editor (I/OCE) instructions and specifications for the Integrated OCE that Medicare uses under the outpatient perspective payment (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 prospective payment system or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these changes.

Background

CR 10385 informs MACs, as well as the fiscal intermediary shared system (FISS) maintainer of the updates to the I/OCE for January 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The Centers for Medicare & Medicaid Services (CMS) will post the I/OCE specifications at *https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html*.The following table summarizes the modifications of the I/OCE for the January 2018 V19.0. Readers should also read through the entire document attached to CR 10385 and note the highlighted sections, which also indicate changes from the prior release of the software. 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
1/1/2018		Updates to the following tables (additional details included in the tables listed in the attachment to CR 10385): Table 1: IOCE control block ▪ Add value codes and value code amounts, up to 36 ▪ Increase the number of condition codes to 30 ▪ Increase the number of occurrence codes to 30 ▪ Remove the following fields: Ndxptr, Nsgptr, NCCptr, NOccptr, CodeTypePtr ▪ Modify the comments for the following fields: Dxeditptr, Proceditptr, Mdeditptr, Dteditptr, Rceditptr, APCptr, Claimptr Table 5: Claim return buffer ▪ Add payer condition code field Table 7: APC return buffer ▪ Add HCPCS modifier field
1/1/2016		Update program logic for drug HCPCS lines with status indicator (SI) of G or K to return the payment ambulatory payment classification (APC) (see processing logic and Appendix E of the attachment to CR 10385).

See **IOCE**, page 28

OPPS

from page 26

Document history

Date of change	Description
December 22, 2017	Initial article released.

MLN Matters® Number: MM10417
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3941CP

Related Change Request (CR) Number: 10417
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

IOCE

from page 27

Effective date	Edits affected	Modification
1/1/2018		Update Appendix K to note the deletion of composite APC 8001.
1/1/2018		Implement program logic for payment reduction of X-rays taken using computed radiography technology. HCPCS codes reporting modifier FY are assigned new payment adjustment flag value 22 (CAA Section 502b reduction on computed radiography) (see special processing section and Appendix G). **Note**: Currently the list of HCPCS codes affected by this logic is the same as that used with modifier FX.
1/1/2018		Implement program logic for OPPS claims to assign a HCPCS level modifier to the line level output when drug HCPCS with SI = K are reported with new modifier JG. The IOCE adds modifier V3 to the line in the new 'HCPCS modifier' field of the program output (see processing logic and Table 7).
1/1/2017	102	Implement new edit 102: Modifiers PO/PN not allowed on the same line (Return to Provider (RTP)). Edit criteria: A claim line has both modifiers PO and PN present (see processing logic, Tables 4 and 5, and Appendix F(a) – Edits by Bill Type).
7/24/2017	103	Implement new edit 103: Modifier reported prior to FDA approval date (Line Item Denial (LID)). Edit criteria: A modifier is reported prior to the mid-quarter activation date (see processing logic, Tables 4 and 5, and Appendix F(a) – Edits by Bill Type).
1/1/2017		Modify program logic for conditional packaging of laboratory services. Laboratory services with SI = Q4 have the SI changed to A if present with an OPPS procedure that has final SI = Q1 with a line item action flag of 2 or 3 applied (see processing logic).

Effective date	Edits affected	Modification
6/5/2017	68	Implement mid-quarter NCD approval edit for procedure code 0421T.
1/1/2018		Update program logic for federally qualified health center (FQHC) claims for new chronic care management codes G0511, G0512. If either code is reported, assign payment indicator = 2 and bypass edits 88 and 89 if no FQHC payment code is reported (see Appendix M).
4/1/2011		Update program logic for services that may be subject to deductible or deductible/ coinsurance waiver. If the services are packaged with SI = N and the line item charges = 0.00, do not assign payment adjustment flags 4, 9 or 10 (see processing logic where payment adjustment flags 4, 9 or 10 are applicable and Appendix G).
1/1/2018	22	Add the following new modifiers to the valid ▪ FY: Computed radiography x-ray ▪ JG: 340B acquired drug ▪ TB: Tracking 340b acquired drug ▪ X1: Continuous/broad services ▪ X2: Continuous/focused services ▪ X3: Episodic/broad services ▪ X4: Episodic/focused services ▪ X5: Svc req by another clinician ▪ 96: Habilitative services modifier list: ▪ 97: Rehabilitative services

See **IOCE**, page 29

IOCE

from page 28

Effective date	Edits affected	Modification
1/1/2018		Update Appendix D to reference HCPCS codes that have SI values different from its APC SI value and impact to discounting (see Appendix D).
10/1/2017		Update program logic for partial hospitalization program (PHP) claims to return payer-defined condition codes in the following instances: ▪ Return condition code MP if the PHP claim represents the initial admit week claim ▪ Return condition code MQ if the PHP claim represents the final discharge week claim **Note**: edit 95 is not returned on an initial admit week or a final discharge week of a PHP claim (see processing logic).
1/1/2018		Update program logic for critical care ancillary services to discontinue the modifier 59 logic exception for code 36600; code no longer identified as critical care ancillary service (see processing logic).
1/1/2018		Add new payment adjustment flag value 22 (see Appendix G).
1/1/2018		Update the following lists for the release (see quarterly data files): ▪ Comprehensive APC ranking ▪ Complexity-adjusted comprehensive APC code pairs ▪ Critical care ancillary services (conditional packaging) ▪ Procedure and sex conflict (edit 8) ▪ Bilateral procedure editing ▪ Blood clotting factor and biologic response HCPCS (edit 99 excusions) ▪ Blood products (edit 73, code updates) ▪ Skin substitute lists (edit 87 – code updates, see Appendix O) ▪ Coinsurance/deductible N/A list (code updates, Appendix O, preventive services) ▪ Device offset code pairs (code pair updates for pass-through device offset logic) ▪ Device-procedure; terminated device-procedures for offset (edit 92, code updates) ▪ Pass-through drugs and biological APC offset amounts ▪ Pass-through skin substitute products (code updates) ▪ Radiation HCPCS for Section 603 (code updates) ▪ CT scan HCPCS subject to NEMA (code updates) ▪ X-ray list for modifiers FX/FY (code updates)

See **IOCE**, page 30

April 2018 quarterly ASP Medicare Part B drug pricing files and revisions to prior quarterly pricing files

Provider type affected

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

Provider action needed

Change request (CR) 10447 instructs MACs to download and implement the April 2018 and, if released, the revised January 2018, October 2017, July 2017, and April 2017 ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) data center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 2, 2018, with dates of service April 1, 2018, through June 30, 2018. Make sure that your billing staffs are aware of these changes.

Background

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

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

For any drug or biological not listed in the ASP or NOC drug pricing files, your MACs will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual* Chapter 17, Section 20.1.3 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*.

For any drug or biological not listed in the ASP or NOC drug pricing files that is billed with the KD modifier, MACs will determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of durable medical equipment on or after January 1, 2017, associated with the passage of the 21st Century Cures Act which is available at *https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf*.

Additional information

The official instruction, CR 10447, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3947CP.pdf*.

See **ASP**, page 31

IOCE

from page 29

Effective date	Edits affected	Modification
1/1/2018		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
1/1/2018	20,40	Implement version **24.0** of the NCCI (as modified for applicable outpatient institutional providers).

Additional information

The official instruction, CR 10385, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3940CP.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
December 22, 2017	Initial article released.

MLN Matters® Number: MM10385
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3940CP
Related Change Request (CR) Number: 10385
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

2018 update for DMEPOS fee schedule

Provider type affected

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

Provider action needed

Change request (CR) 10395 provides the 2018 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

Section 1834(a), (h), and (i) of the Social Security Act (the Act) requires payment on a fee schedule for certain DMEPOS. Also, payment on a fee-schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints, casts, and Intraocular Lenses (IOLs) inserted in a physician's office.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Regulations at 42 CFR Section 414.210(g) established the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. Recent program instructions on these changes are available in Transmittal 3551, CR 9642, dated June 23, 2016 (MM9642 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9642.pdf*), and Transmittal 3416, CR 9431, dated November 23, 2015 (MM9431 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9431.pdf*).

The DMEPOS and parenteral and enteral nutrition (PEN) fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated pursuant to 42 CFR Section 414.210(g)(8) when information from the CBPs is updated.

Pursuant to 42 CFR Section 414.210(g)(4), for items where the single payment amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs are increased by the percentage changes in the consumer price index for all urban consumers (CPI-U) from the last year of the applicable CBP to the current year. Information on the update factor for 2018 is included below.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental metropolitan statistical areas (MSAs) are not included in the DMEPOS rural ZIP code file. The DMEPOS rural ZIP code file is updated on a quarterly basis, as necessary. Regulations at 42 CFR 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also included any ZIP code within an MSA that is excluded from a competitive bidding area established for that MSA.

The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Also, the PEN fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parenteral nutrition items.

The DMEPOS and PEN fee schedules and the rural ZIP code public use files (PUFs) will be available for state Medicaid agencies, managed care organizations,

See **DMEPOS**, page 32

ASP

from page 30

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
January 5, 2018	Initial article released.

MLN Matters® Number: MM10447

Related CR Release Date: January 5, 2018
Related CR Transmittal Number: R3947CP
Related Change Request (CR) Number: 10447
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

DMEPOS

from page 31

and other interested parties at *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched*.

New codes added

- New DMEPOS codes added to the HCPCS file, effective January 1, 2018, where applicable, are:
- E0953 and E0954 in the inexpensive/routinely purchased (IN) payment category
- L3761, L7700, L8625, L8694, and Q0477, which are all in the prosthetics and orthotics (PO) payment category.

For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2017 by the payment category are:

- 0.447 for oxygen
- 0.450 for capped rental
- 0.451 for prosthetics and orthotics
- 0.572 for surgical dressings
- 0.623 for parental and enteral nutrition
- 0.953 for splints and casts
- 0.937 for intraocular lenses

Codes deleted

No HCPCS codes will be deleted from the DMEPOS fee schedule files effective January 1, 2018.

Specific coding and pricing issues

Effective January 1, 2018, new off-the-shelf orthotic (OTS) code L3761 - Elbow orthosis (EO), with adjustable position locking joint(s) prefabricated off-the-shelf - is included in the fee schedule file. Code L3760 was split into two codes: The existing code revised, effective January 1, 2018, to only describe devices customized to fit a specific patient by an individual with expertise, and a new code describing OTS items (L3761).

The fee schedule amount for existing code L3760 will be applied to new code L3761 effective January 1, 2018. The cross-walking of fee schedule amounts for a single code that is split into two codes for distinct complete items is in accordance with the instructions stated in Chapter 3, Section 60.3.1 of the *Medicare Claims Processing Manual*. An update will be made to the list of orthotic codes that are designated as OTS at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html* to reflect added code L3761.

As part of this update, a corrected calculation is applied to the adjusted fee schedule amounts for codes A4619, E0147, and E0580. The fee schedule adjustment methodology at 42 CFR 414.210(g) was incorrectly applied to these codes, and therefore corrections to the adjusted fee schedule amounts for these codes have been made.

Effective January 1, 2018, the replacement external sound processor (HCPCS code L8691) is split into two codes in order to appropriately identify devices where the actuator is a separate component from the sound processor, microphones, and battery. The two codes are a revised L8691 and a new L8694 transducer/actuator code.

Effective January 1, 2018, the existing fee schedules for L8691 are revised to remove payment for the separate transducer/actuator component. Suppliers billing for replacement sound processors that do not separate the sound processor and the actuator should use both L8691 and L8694 to describe the replaced items. Suppliers billing for replacement sound processors that separate the sound processor and the actuator components should use either or both L8691 and L8694 as appropriate to describe the sound processor component(s).

The replacement ventricular assist device (VAD) power module code Q0479 is split in order to separately identify the patient cable. Effective January 1, 2018, HCPCS code Q0477 identifies a replacement patient cable. Thus, the fees for Q0479 are revised to reflect the establishment of the new patient cable code.

The Centers for Medicare & Medicaid Services (CMS) is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2018, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2016. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2018.

As part of this file update, the jurisdiction for HCPCS code E0781 is revised from ‘J’ to ‘D’.

HCPCS code Q0477 (Power Module Patient Cable for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only) is being added to the HCPCS file, effective January 1, 2018, to describe a replacement accessory for Ventricular Assist Devices (VADs). Similar to the other VAD supplies and accessories coded at Q0478 thru Q0495, Q0497-Q0502, and Q0504 thru Q0509, CMS has determined the reasonable useful lifetime for code Q0477 to be one year. Therefore, CMS will deny claims for Q0477 before the lifetime of these items has expired. Suppliers and providers will need to add modifier RA to claims for code Q0477 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

See **DMEPOS**, page 33

DMEPOS

from page 32

Fees for the 'KU' modifier when billed with wheelchair codes E0953 and E0954 are included in the January 2018 file for billing when these items are furnished in connection with Group 3 complex rehabilitative power wheelchairs.

Diabetic testing supplies

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are not updated by the annual covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they are equal to the single payment amounts (SPAs) for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act. The national mail-order recompete DTS SPAs are available at *https://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*.

The non-mail order DTS amounts on the fee schedule file will be updated each time the SPAs are updated. This can happen no less often than every time the mail order CBP contracts are recompeted. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are included in Transmittal 2709, Change request (CR) 8325, dated May 17, 2013, and Transmittal 2661, CR 8204, dated February 22, 2013. You can review related article MM8325 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf* and MM8204 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf*.

2018 fee schedule update factor of 1.1 percent

For 2018, an update factor of 1.1 percent is applied to certain DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2018 by the percentage increase in the CPI- U for the 12-month period ending June 30, 2017, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 1.6 percent. Thus, the 1.6 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a net increase of 1.1 percent for the update factor.

2018 update to the labor payment rates

The 2018 allowed payment amounts for HCPCS labor payment codes K0739, L4205, and L7520 are in the table below. Since the percentage increase in the CPI- U for the 12-month period ending with June 30, 2017, is 1.6 percent, this change is applied to the 2017 labor payment amounts to update the rates for 2018.

State	K0739	L4205	L7520
AK	$28.74	$32.75	$38.53
AL	$15.26	$22.74	$30.87
AR	$15.26	$22.74	$30.87
AZ	$18.87	$22.71	$37.98
CA	$23.41	$37.33	$43.49
CO	$15.26	$22.74	$30.87
CT	$25.48	$23.25	$30.87
DC	$15.26	$22.71	$30.87
DE	$28.09	$22.71	$30.87
FL	$15.26	$22.74	$30.87
GA	$15.26	$22.74	$30.87
HI	$18.87	$32.75	$38.53
IA	$15.26	$22.71	$36.95
ID	$15.26	$22.71	$30.87
IL	$15.26	$22.71	$30.87
IN	$15.26	$22.71	$30.87
KS	$15.26	$22.71	$38.53
KY	$15.26	$29.11	$39.47
LA	$15.26	$22.74	$30.87
MA	$25.48	$22.71	$30.87
MD	$15.26	$22.71	$30.87
ME	$25.48	$22.71	$30.87
MI	$15.26	$22.71	$30.87
MN	$15.26	$22.71	$30.87
MO	$15.26	$22.71	$30.87
MS	$15.26	$22.74	$30.87
MT	$15.26	$22.71	$38.53
NC	$15.26	$22.74	$30.87
ND	$19.02	$32.67	$38.53
NE	$15.26	$22.71	$43.04
NH	$16.39	$22.71	$30.87
NJ	$20.58	$22.71	$30.87
NM	$15.26	$22.74	$30.87
NV	$24.31	$22.71	$42.07
NY	$28.09	$22.74	$30.87
OH	$15.26	$22.71	$30.87
OK	$15.26	$22.74	$30.87
OR	$15.26	$22.71	$44.38
PA	$16.39	$23.39	$30.87
PR	$15.26	$22.74	$30.87
RI	$18.19	$23.41	$30.87
SC	$15.26	$22.74	$30.87
SD	$17.06	$22.71	$41.27
TN	$15.26	$22.74	$30.87

See **DMEPOS**, page 34

DMEPOS

from page 33

State	K0739	L4205	L7520
TX	$15.26	$22.74	$30.87
UT	$15.30	$22.71	$48.07
VA	$15.26	$22.71	$30.87
VI	$15.26	$22.74	$30.87
VT	$16.39	$22.71	$30.87
WA	$24.31	$33.31	$39.58
WI	$15.26	$22.71	$30.87
WV	$15.26	$22.71	$30.87
WY	$21.28	$30.31	$43.04

2018 national monthly fee schedule amounts for stationary oxygen equipment

CMS is implementing the 2017 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service from January 1, 2018, through December 31, 2018. As required by statute, the addition of the separate payment classes for oxygen generating portable equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral. Medicare expenditures must account for these separate oxygen payment classes.

Therefore, the fee schedule amounts for stationary oxygen equipment are reduced by a certain percentage each year to balance the increase in payments made for the additional separate oxygen payment classes. For dates of service January 1, 2018, through December 31, 2018, the monthly fee schedule payment amounts for stationary oxygen equipment range from approximately $66 to $76 incorporating the budget neutrality adjustment factor.

When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2018 maintenance and servicing payment amount for certain oxygen equipment

CMS is also updating for 2018 the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR 6792, dated February 5, 2010, and Transmittal 717, CR 6990, dated June 8, 2010.(You can review related articles MM6792 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf* and MM6990 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf*.) To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR 414.210(e)(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2017 maintenance and servicing fee is adjusted by the 1.1 percent MFP-adjusted covered item update factor to yield a 2018 maintenance and servicing fee of $70.74 for oxygen concentrators and transfilling equipment.

Additional information

The official instruction, CR 10395, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3931CP.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
January 5, 2018	Initial article released.

MLN Matters® Number: MM10395
Related CR Release Date: December 1, 2017
Related CR Transmittal Number: R3931CP
Related Change Request (CR) Number: 10395
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Summary of policies in the 2018 MPFS final rule and the telehealth originating site facility fee payment, and CT modifier reduction

Provider type affected

This *MLN Matters*® article is intended for physicians and other providers who submit claims to Medicare administrative contractors (MACs) for services paid under the Medicare physician fee schedule (MPFS) and provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10393 provides a summary of policies in the 2018 MPFS final rule and announces the telehealth originating site facility fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in 2018. Make sure your billing staffs are aware of these updates.

Background

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary of Health and Human Services to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule November 2, 2017, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in 2018.

The final rule, CMS-1676-F, also addresses public comments on Medicare payment policies proposed earlier this year. The final rule, *Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018,* was published in the *Federal Register* November 2, 2017. The key changes are as follows:

Overall payment update and misvalued code target

The overall update to payments under the MPFS based on the finalized 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience (ABLE) Act of 2014.

After applying these adjustments and the budget neutrality adjustment to account for changes in relative resource units (RVUs), all required by law, the final 2018 physician fee schedule (PFS) conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

Payment rates for non-excepted off-campus provider-based hospital departments paid under the MPFS

Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the outpatient prospective payment system (OPPS) beginning January 1, 2017. For 2017, CMS finalized the MPFS as the applicable payment system for most of these items and services.

For 2018, CMS is finalizing a reduction to the current MPFS payment rates for these items and services by 20 percent. CMS currently pays for these services under the MPFS based on a percentage of the OPPS payment rate. Specifically, the final policy will change the MPFS payment rates for these services from 50 percent of the OPPS payment rate to 40 percent of the OPPS rate. CMS believes that this adjustment will provide a more level playing field for competition between hospitals and physician practices by promoting greater payment alignment.

Telehealth originating site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for 2017 is 1.2 percent. Therefore, for 2018, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $25.76. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Medicare telehealth services

For 2018, CMS is finalizing the addition of several codes to the list of telehealth services, including:

- HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility)
- CPT® code 90785 (interactive complexity)
- CPT® codes 96160 and 96161 (health risk assessment)
- HCPCS code G0506 (care planning for chronic care management)
- CPT® codes 90839 and 90840 (psychotherapy for crisis)

Additionally, CMS is finalizing its proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners. CMS is also finalizing separate payment for CPT® code 99091, which describes certain remote patient monitoring, for 2018. This code is payable in both non-facility and facility settings.

See **POLICIES**, page 36

POLICIES

from page 35

In addition, CMS stated the following in the 2018 MPFS final rule (82 FR 53014):

- CMS is adopting CPT® prefatory guidance that this code should be billed no more than once every 30 days.
- CMS is allowing CPT® code 99091 to be billed once per patient during the same service period as chronic care management (CCM) (CPT® codes 99487, 99489, and 99490), transitional care management (TCM) (CPT® codes 99495 and 99496), and behavioral health integration (BHI) services (CPT® codes 99492, 99493, 99494, and 99484).
- CMS is requiring that the practitioner obtain advance beneficiary consent for the service and document this in the patient's medical record.
- For new patients or patients not seen by the billing practitioner within one year prior to billing CPT® code 99091, CMS requires initiation of the service during a face-to-face visit with the billing practitioner, such as an annual wellness visit or initial preventive physical exam, or other face-to-face visit with the billing practitioner.

Lastly, CMS will consider the stakeholder input received in response to the proposed rule's comment solicitation on how CMS could expand access to telehealth services, within the current statutory authority.

Care management services

CMS is continuing efforts to improve payment within traditional fee-for-service Medicare for CCM and similar care management services to accommodate the changing needs of the Medicare patient population. CMS is finalizing its proposals to adopt CPT® codes for 2018 for reporting several care management services currently reported using Medicare G-codes. Also, CMS is clarifying a few policies regarding CCM in this final rule.

Improvement of payment rates for office-based behavioral health services

CMS is finalizing an improvement in the way MPFS rates are set that will positively impact office-based behavioral health services with a patient. The final policy will increase payment for these important services by better recognizing overhead expenses for office-based face-to-face services with a patient.

Evaluation and management comment solicitation

Most physicians and other practitioners bill patient visits to the MPFS under a relatively generic set of codes that distinguish level of complexity, site of care, and in some cases whether or not the patient is new or established. These codes are called evaluation and management (E/M) visit codes. Billing practitioners must maintain information in the medical record that documents that they have reported the appropriate level of E/M visit code. CMS maintains guidelines that specify the kind of information that is required to support Medicare payment for each level.

CMS agrees with continued feedback from stakeholders that these guidelines are potentially outdated and need to be revised. CMS thanks the public for the comments received in response to the proposed rule's comment solicitation on the E/M guidelines and summarizes these comments in the final rule. Commenters suggested that CMS provide additional avenues for collaboration with stakeholders prior to implementing any changes. CMS will consider the best approaches for such collaboration and will take the public comments into account as it considers the issue in future rulemaking.

Prolonged preventive services

CMS is adding new codes for prolonged preventive services. Prolonged preventive services are add-on codes payable by Medicare when billed with an applicable preventive service that is both payable from the MPFS, and both deductible and coinsurance do not apply. For the complete list of codes that may be billed with prolonged preventive services visit *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html*.

Payments for imaging services that are X-rays taken using computed radiography

CMS is finalizing policy required by Section 1848(b)(9) of the Act, which requires payments for imaging services that are X-rays taken using computed radiography (including the technical component portion of a global service) furnished during 2018-2022, that would otherwise be made under the MPFS (without application of subparagraph (B)(i) and before application of any other adjustment), be reduced by seven percent.

Solicitations on burden reduction

CMS solicited comments on burden reduction on several issues including E/M, telehealth and remote patient monitoring. CMS appreciates the thoughtful input it received in response to these comment solicitations and will consider their input in future rulemaking.

Cognitive therapy services

CMS will retain the coding and valuation of cognitive therapy services through the creation of HCPCS code G0515 that will mirror CPT® code 97532 deleted for 2018 instead of valuing CPT® code 97127. CMS will assign status indicator "I" to CPT® code 97127 to indicate that it is "Invalid" for Medicare purposes. HCPCS code G0515 has been added to the therapy code list, see CR 10303 for more information. *MLN Matters*® article MM10303 discusses CR 10303 and it is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10303.pdf*.

Additional information

The official instruction, CR 10393, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3938CP.pdf*.

See **POLICIES**, page 37

April 2018 changes to the laboratory NCD edit software

Provider type affected

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

What you need to know

This article is based on change request (CR) 10424 which informs MACs about the changes that will be included in the April 2018 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

Background

CR 10424 announces the changes that will be included in the April 2018 quarterly release of the edit module for clinical diagnostic laboratory services. The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12-190.34) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. CR 10424 communicates requirements to MACs notifying them of changes to the laboratory edit module for laboratory NCD code lists for April 2018. Please access the following link for the NCD spreadsheets included with CR 10424:

https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/April2018.zip

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

Additional information

The official instruction, CR 10424, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3937CP.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
January 3, 2018	Initial article released.

MLN Matters® Number: MM10424
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3937CP
Related Change Request (CR) Number: CR10424
Effective Date: October 1, 2017
Implementation Date: April 2, 2018

POLICIES

from page 36

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
December 26, 2017	Initial article released.

MLN Matters® Number: MM10393
Related CR Release Date: December 22, 2017
Related CR Transmittal Number: R3938CP
Related Change Request (CR) Number: 10393
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

ICD-10 and other coding revisions to NCDs

***Note**: This article was revised January 19, 2018, to reflect a revised change request (CR) 10318 issued January 18. In the article, the CR release date, MAC implementation date, transmittal number, and the web address of the CR are revised. All other information remains the same. This information was previously published in the December 2017 Medicare A Connection, pages 49-50.*

Provider type affected

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

Provider action needed

CR 10318 constitutes a maintenance update of the International Code of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR:

https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10318.zip

Background

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

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

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

CR 10318 makes coding and clarifying adjustments to the following NCDs:

1. NCD20.9 Artificial Hearts
2. NCD20.9.1 Ventricular Assist Devices (VADs)
3. NCD20.16 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)
4. NCD20.29 Hyperbaric Oxygen (HBO) Therapy
5. NCD20.30 Microvolt T-Wave Alternans (MTWA)
6. NCD20.33 Transcatheter Mitral Valve Repair (TMVR)
7. NCD40.1 Diabetes Self-Management Training (DSMT)
8. NCD80.2, 80.2.1, 80.3, 80.3.1 Photodynamic Therapy, OPT, Photosensitive Drugs, Verteporfin
9. NCD110.18 Aprepitant
10. NCD110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer
11. NCD110.23 Stem Cell Transplants
12. NCD160.27 Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)
13. NCD190.3 Cytogenetic Studies
14. NCD190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) for Anticoagulation Management
15. NCD220.4 Mammograms
16. NCD220.6.17 Positron Emission Tomography (FDG) for Solid Tumors
17. NCD260.1 Adult Liver Transplantation
18. NCD220.13 Percutaneous Image-Guided Breast Biopsy
19. NCD270.1 Electrical Stimulation/Electromagnetic Therapy (ES/ET) for Wounds
20. NCD270.3 Blood-Derived Products for Chronic Non-Healing Wounds
21. NCD80.11 Vitrectomy

When denying claims associated with the above NCDs, except where otherwise indicated, MACs will use.

See **ICD-10**, page 39

ICD-10

from page 38

- Remittance advice remark codes (RARC) N386 with claim adjustment reason code (CARC) 50, 96, and/or 119.
- Group code PR (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed advance beneficiary notice (ABN) is on file).
- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
- For modifier GZ, use CARC 50

Additional information

The official instruction, CR 10318, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R2005OTN.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
January 19, 2018	The article was revised due to a revised CR 10318 issued January 18. In the article, the CR release date, MAC implementation date, transmittal number, and the web address of the CR are revised. All other information remains the same.

Date of change	Description
November 16, 2017	Initial article released.

MLN Matters® Number: MM10318 *Revised*
Related Change Request (CR) Number: 10318
Related CR Release Date: January 18, 2018
Effective Date: April 1, 2018 - Unless otherwise noted in CR 10318
Related CR Transmittal Number: R2005OTN
Implementation Date: January 29, 2018, for local MAC edits; April 2, 2018, for shared system edits (except FISS for NCDs (see above) 1, 8, 12, 19, 21); July 2, 2018, FISS only for NCDs 1, 8, 12, 19, 21

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RHC and FQHC 'Medicare Benefit Policy Manual' Chapter 13 update

Note: *This article was revised January 10, 2018, to reflect a revised change request (CR) 10350 issued January 9. In the article, the effective and implementation dates are revised. 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 December 2017 Medicare A Connection, pages 50-51.*

Provider type affected

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

Provider action needed

Change request (CR) 10350 notifies RHCs and FQHCs of updates to Chapter 13 of the *Medicare Benefit Policy Manual* (Pub. 100-02). These updates clarify payment and other policy information. Make sure your billing staffs are aware of these updates.

Background

The 2018 update of Chapter 13 of the *Medicare Benefit Policy Manual* – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services – provides information on requirements and payment policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act. This chapter now includes payment policy for care management in RHCs and FQHCs as finalized in the 2018 physician fee schedule final rule. All other revisions serve to clarify existing policy.

New manual sections relevant to care management services in RHCs and FQHCs include:

- Section 230 – Care Management Services
- Section 230.1 – Transitional Care Management Services
- Section 230.2 – General Care Management Services – Chronic Care Management and General Behavioral Health Integration Services
- Section 230.3 – Psychiatric Collaborative Care Model (CoCM) Services

The revised chapter is attached to CR 10350.

Additional information

You may view CR 10350 and the revised manual sections at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R239BP.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
January 10, 2018	The article was revised to reflect a revised CR 10350 issued January 9. In the article, the effective and implementation dates are revised. Also, the CR release date, transmittal number and the Web address for accessing the CR are revised. All other information remains the same.
November 17, 2017	Initial article released.

MLN Matters® Number: MM10350 *Revised*
Related CR Release Date: January 9, 2018
Related CR Transmittal Number: R239BP
Related Change Request (CR) Number: 10350
Effective Date: January 22, 2018
Implementation Date: January 22, 2018

Medically unlikely edits and bilateral surgical procedures

***Note**: This article was revised with more details and examples and was re-issued January 17, 2018. Providers who perform bilateral surgical procedures should review the entire article. This information was previously published in the July 2014 Medicare A Connection, pages 11-12.*

Provider type affected

This *MLN Matters*® special edition article is intended for all Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, and other health care professionals who bill Medicare administrative contractors (MACs) for bilateral surgical procedures for Medicare beneficiaries using the physician fee schedule (PFS).

Provider action needed

The purpose of this article is to inform providers that medically unlikely edits (MUEs) may render certain claim lines for bilateral surgical procedures unpayable. Providers and suppliers that bill using the PFS are reminded that Medicare billing instructions require claims for certain bilateral surgical procedures to be filed using a 50 modifier and one unit of service (UOS).

Make sure your billing staffs examine their process for filing claims for bilateral surgical procedures and services to ensure the 50 modifier is used in accordance with Medicare correct coding and claims submission instructions.

Background

Healthcare Common Procedure Coding System (HCPCS) coding for bilateral surgical procedures differs from CPT® coding guidelines.

Coding claims for surgical procedures performed bilaterally depends on:

- The HCPCS code descriptor,
- The "bilateral indicator" assigned to the HCPCS code (that is, whether special payment rules apply), and
- The nature of the service.

The *National Correct Coding Initiative (NCCI)* manual specifies that modifier 50 is used to report bilateral surgical procedures as a single UOS. The NCCI manual warns that MUE edits based on established CMS policies may limit units of service and are predicated on the assumption that claims are coded in accordance with these Medicare instructions. Consequently, many bilateral procedures have an MUE value of 1.

Bilateral indicators only apply to the physician fee schedule (PFS) and not to other Medicare payment systems.

Bilateral indicators

Bilateral indicator	What does this bilateral indicator mean?
0	**No bilateral payment adjustment** 150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier 50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides and (b) 100 percent of the fee schedule amount for a single code. **Example**: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) because of physiology or anatomy, or (b) because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.
1	**150 percent bilateral payment adjustment** 150 percent payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a two in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.

See **MUE**, page 42

MUE

from page 41

Bilateral indicator	What does this bilateral indicator mean?
2	**Bilateral procedure** 150 percent payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier 50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a two in the units field), base the payment for both sides on the lower of (a) the total actual charge by the physician for both sides, or (b) 100 percent of the fee schedule for a single code. **Example**: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment should be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.
3	**No bilateral payment adjustment** The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier 50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a two in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100 percent of the fee schedule amount for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the fee schedule amount for a bilateral procedure before applying any multiple procedure rules. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral surgeries.

Request for reopening of a claim

For all MUE edit denials, including both MAI of two and three, if the provider identifies a clerical error and the correct value is equal to or less than the MUE, the provider may request a reopening (i.e., a clerical error reopening (CER)) to correct its billing of the claim as an alternative to filing a formal appeal. Providers can request a CER through their Medical administrative contractor. providers are reminded this approach is allowable to redress underpayments resulting from unintentional errors, but it nonetheless delays full payment. For example, if the provider identifies a denial of a bilateral surgical service because it was billed with two UOS instead of being billed with one UOS and a 50 modifier, the provider may request a reopening to correct the coding/billing error, although providers should be aware that reopening requests do not extend the window for filing appeals. More importantly, though, the provider should bring his billing into compliance with CMS instructions, using one UOS and the 50 modifier to avoid future denials and delays in payment.

Additional information

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work.

You may also want to review the following publications:

For information on clerical error reopenings (CERs) consult the *Claims Processing Manual* Pub. 100-04 Chapter 34 and work with your Medicare administrative contractor

For information on MUE adjudication indicators (MAIs) review the Revised Modification to the Medically Unlikely Edit (MUE) Program available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8853.pdf*.

See **MUE**, page 43

MUE

from page 42

For information on reporting hospital outpatient services using Healthcare Common Procedure Coding System (HCPCS) consult the *Claims Processing Manual* Pub. 100-04 Chapter 4 Section 20.6 - Use of Modifiers.

A podcast transcript on the MUEs at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/2015-05-21-Medically-Unlikely-Edits-Compliant-PodcastTranscript.pdf*.

MLN Matters® article MM6526 "Payment of Bilateral Procedures in a Method II Critical Access Hospital (CAH)" at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6526.pdf*.

Document history

Date of change	Description
January 17, 2018	This article was revised with more details and examples and was re-issued.
June 30, 2014	Initial article released.

MLN Matters® Number: SE1422 *Revised*
Related Change Request (CR) #: N/A
Article Release Date: January 17, 2018
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Examples of correct coding for bilateral surgical procedures for PFS

Bilateral indicator	Expected units of service if performed bilaterally	Modifier based on laterality	HCPCS code descriptor and *explanation of correct coding*
1	1	50	23515 Open treatment of clavicular fracture, includes internal fixation, when performed. *The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier "-50" as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.*
2	1		52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral**. *The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50".*
2	1		64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). *The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50".*

See **MUE**, page 44

MUE

from page 43

Examples of incorrect coding for bilateral surgical procedures for PFS

Bilateral indicator	Expected units of service if performed bilaterally	Modifier based on laterality	Second modifier	HCPCS code descriptor and *explanation of incorrect coding*
1	1	RT	LT	23515 Open treatment of clavicular fracture, includes internal fixation, when performed. *The code descriptor does not identify this procedure as a bilateral procedure (or unilateral or bilateral), so when performed bilaterally at the same operative session physicians must report the procedure with modifier "-50" as a single line item using one UOS. Do not use modifiers RT and LT when modifier -50 applies.*
2	1		LT	52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral**. *The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50". Do not report the procedure using two line items using RT and LT modifiers.*
2	1	RT		52290 Cystourethroscopy; with ureteral meatotomy, **unilateral or bilateral**. *The code descriptor identifies this procedure as a unilateral or bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item and do not report the procedure with modifier "-50". Do not report the procedure using two line items using RT and LT modifiers.*
2	2			64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). *The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item. Do not report two UOS.*
2	1	50		64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) **bilateral**; by injections (includes imaging guidance, when performed). *The code descriptor identifies this procedure as a bilateral procedure, so when performed bilaterally at the same operative session report one UOS as a single line item. Do not report the procedure with modifier "-50".*

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

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 January 4, 2018

MLN Connects® for January 4, 2018

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News & Announcements

- CMS Launches Data Submission System for Clinicians in the Quality Payment Program
- CMS Updates Website to Compare Hospital Quality
- Patients over Paperwork: Get Updates on Burden Reduction
- Quality Payment Program: Qualified Registries and QCDRs
- Quality Payment Program Resources
- EHR Incentive Program Hospitals: Use QNet to Attest
- Medicare Diabetes Prevention Program Resources
- Post-Acute Care Quality Reporting Program Section GG Web-based Training
- Hospice Compare Update
- Are You Prepared for a Health Care Emergency?
- Get Your Patients Off to a Healthy Start in 2018

Provider Compliance

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

Upcoming Events

- Low Volume Appeals Settlement Option Call – January 9
- ESRD QIP: Final Rule for CY 2018 Call – January 23

Medicare Learning Network Publications & Multimedia

- Dementia Care Call: Audio Recording and Transcript – New
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet – Revised

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.

MLN Connects® for January 11, 2018

MLN Connects® for January 11, 2018

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News & Announcements

- CMS Launches Data Submission System for Clinicians in the Quality Payment Program
- CMS Updates Website to Compare Hospital Quality
- Patients over Paperwork: Get Updates on Burden Reduction
- Quality Payment Program: Qualified Registries and QCDRs
- Quality Payment Program Resources
- EHR Incentive Program Hospitals: Use QNet to Attest
- Medicare Diabetes Prevention Program Resources
- Post-Acute Care Quality Reporting Program Section GG Web-based Training
- Hospice Compare Update
- Are You Prepared for a Health Care Emergency?
- Get Your Patients Off to a Healthy Start in 2018

Provider Compliance

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

Upcoming Events

- Low Volume Appeals Settlement Option Call – January 9
- ESRD QIP: Final Rule for CY 2018 Call – January 23

Medicare Learning Network Publications & Multimedia

- Dementia Care Call: Audio Recording and Transcript – New
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet – Revised

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MLN Connects® for January 18, 2018

MLN Connects® for January 18, 2018

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News & Announcements

- 2018 Value Modifier Results and Payment Adjustment Factor
- Final DMEPOS Quality Standards for Therapeutic Shoe Inserts
- Glaucoma Awareness Month: Make a Resolution for Healthy Vision

Provider Compliance

- CMS Provider Minute Video: CT Scans — Reminder

Upcoming Events

- New Medicare Card Project Special Open Door Forum — January 23
- ESRD QIP: Final Rule for CY 2018 Call — January 23
- MIPS Annual Call for Measures and Activities Webinar — February 5
- Comparative Billing Report on Opioid Prescribers Webinar — February 21

Medicare Learning Network Publications & Multimedia

- QRUR Video Presentation — New

- Low Volume Appeals Settlement Call: Audio Recording and Transcript — New
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Revised
- How to Use the Medicare Coverage Database Booklet — Revised
- Behavioral Health Integration Services Fact Sheet — Revised

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First Coast Service Options Phone Numbers

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

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

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

Interactive Voice Response
877-602-8816

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

Overpayments
904-791-8123

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

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

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

Puerto Rico

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

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

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

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

General Inquiries
Online Form (Click here)
Email: *EDOC-CS-FLINQA@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