Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

March 2018

In this issue

Adjustments to QMB claims processed under CR 9911

Provider type affected

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

Provider action needed

This article is based on change request (CR) 10494 which directs MACs to mass adjust QMB claims impacted by CR 9911. (An article related to CR 9911 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9911.pdf*.) Make sure that your billing staff is aware of these upcoming claims adjustments.

Background

CR 9911 incorporates claim processing system modifications implemented October 2, 2017, to generate QMB information in remittance advices (RAs) and Medicare summary notices. Providers may use RAs to bill state Medicaid agencies and other secondary payers outside the coordination of benefits agreement (COBA) crossover process, but CR 9911 RAs lacked the formatting and specificity that states require to process QMB cost-sharing claims.

To address these issues, December 8, 2017, the Centers for Medicare & Medicaid Services (CMS) temporarily suspended the CR 9911 claim processing system modifications. See "QMB Remittance Advice Issue" at *https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MM9911Update112017.pdf*.

Through CR 10433, CMS will reintroduce QMB information in the RA starting July 2018 and modify CR 9911 to avoid disrupting claim processing by secondary payers. CR 10433 will be effective for claims processed on or after July 2, 2018. A related article is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10433.pdf*.

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

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

ADJUSTMENTS

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Under CR 10494, MACs will initiate non-monetary mass adjustments for claims impacted by CR 9911 QMB RA changes, which include claims that were paid after October 2, 2017 and up to December 31, 2017, and that have not been voided or replaced. MACs will issue replacement RAs without the CR 9911 changes and re-process QMB cost-sharing claims by secondary payers by December 20, 2018, for Part B/MAC claims and by September 20, 2018, for Part A/MAC and durable medical equipment MAC claims.

Providers may use the new RAs to resubmit state Medicaid QMB cost-sharing claims that states initially failed to pay due to CR 9911 QMB RA changes. To avoid duplicate claims, providers should not resubmit claims that secondary payers successfully processed through direct claim submission or the COBA process.

Note that although mass-adjusted claims may not cross over, this solution targets affected providers who attempted to bill supplemental payers directly using CR 9911 QMB RAs because their QMB cost-sharing claims either did not cross over or crossed over to supplemental payers but failed to process. The goal is to produce replacement Medicare RAs that providers can submit to supplemental payers to coordinate benefits as necessary.

Make sure your billing staff is aware of these changes.

Additional information

The official instruction, CR 10494, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2042OTN.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
March 22, 2018	Initial article released.

MLN Matters® Number: MM10494
Related CR Release Date: March 16, 2018
Related CR Transmittal Number: R2042OTN
Related Change Request (CR) Number: 10494
Effective Date: December 20, 2018, for Part B MAC claims and September 20, 2018, for Part A and DME MAC claims
Implementation Date: December 20, 2018, for Part B MAC claims and September 20, 2018, for Part A and DME MAC claims

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.

Reinstating the QMB indicator in the Medicare fee-for-service claim processing system from CR 9911

***Note**: This article was revised March 13, 2018, to reflect an updated change request (CR). That CR added CARCs 66, 247, and 248. DME MACs were added to the "Providers affected" section and the QMB enrollment numbers were also updated under "Background" to reflect 2016 statistics. Pharmacies were also included in "Background." The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged. This revision was previously published in the February 2018 Medicare A Connection, pages 4-5.*
Note: Editorial corrections made May 23, 2018, to the "Provider type affected" section to include DME MACs and the "Background" section to include pharmacies.

Provider type affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Part A/B and durable medical equipment (DME) Medicare administrative contractors (MACs).

What you need to know

Effective with CR 10433, the Centers for Medicare & Medicaid Services (CMS) will reintroduce qualified Medicare beneficiary (QMB) information in the Medicare remittance advice (RA) and Medicare summary notice (MSN). CR 9911 modified the fee-for-service (FFS) systems to indicate the QMB status and zero cost-sharing liability of beneficiaries on RAs and MSNs for claims processed on or after October 2, 2017. On December 8, 2018, CMS suspended CR 9911 to address unforeseen issues preventing the processing of QMB cost-sharing claims by states and other secondary payers outside of the coordination of benefits agreement (COBA) process. CR 10433 remediates these issues by including revised "alert" remittance advice remark codes (RARC) in RAs for QMB claims without adopting other RA changes that impeded claim processing by secondary payers. CR 10433 reinstates all changes to the MSNs under CR 9911. Please make sure your billing staff is aware of these changes.

Background

Federal law bars Medicare providers and suppliers, **including pharmacies**, from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances. (See Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.) The QMB program is a state Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

Providers and suppliers, including pharmacies, may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, states may limit Medicare cost-sharing payments, under certain circumstances. Be aware, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

System changes to assist providers under CR 9911

To help providers more readily identify the QMB status of their patients, CR 9911 introduced a QMB indicator in the claims processing system for the first time. CR 9911 is part of the CMS ongoing effort to give providers tools to comply with the statutory prohibition on collecting Medicare A/B cost-sharing from QMBs.

Through CR 9911, CMS indicated the QMB status and zero cost-sharing liability of beneficiaries in the RA and MSN for claims processed on or after October 2, 2017. In particular, CR 9911 changed the MSN to include new messages for QMB beneficiaries and reflect $0 cost-sharing liability for the period they are enrolled in QMB. In addition, CMS modified the RA to include new alert RARCs to notify providers to refrain from collecting Medicare cost-sharing because the patient is a QMB (N781 is associated with deductible amounts and N782 is associated with coinsurance).

Additionally, CR 9911 changed the display of patient responsibility on the RA by replacing claim adjustment group code "patient responsibility" (PR) with group code "other adjustment" (OA). CMS zeroed out the deductible and coinsurance amounts associated with claim adjustment reason code (CARC) 1 (deductible) and/or 2 (coinsurance) and used CARC 209 – ("Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to the patient if collected. (Use only with group code OA).")

However, the changes to the display of patient liability in the RAs for QMB claims caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to states and other payers secondary to Medicare. Providers rely on RAs to bill state Medicaid Agencies and other secondary payers outside the Medicare COBA claims crossover process. States and other secondary payers generally require RAs that separately display the Medicare deductible and coinsurance amounts with the claim adjustment group code "PR" and associated CARC codes and could not process claims involving the RA changes from CR 9911. Barriers to the processing of secondary claims have additional implications for institutional providers that claim bad debt under the Medicare program since they must obtain a Medicaid remittance advice to seek reimbursement for unpaid deductibles and coinsurance as a Medicare bad debt for QMBs.

To address these issues, on December 8, 2017, CMS suspended the CR 9911 system changes causing the claim processing systems to suspend the RA and MSN changes for QMB claims under CR 9911.

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Reintroduction of QMB information in the MA and MSN under CR 10433

Effective with CR 10433, the claim processing systems will reintroduce QMB information in the RA without impeding claim processing by secondary payers.

The RA for QMB claims will retain the display of patient liability amounts needed by secondary payers to process QMB cost-sharing claims.

All Medicare's FFS systems will discontinue the practice of outputting claim adjustment group code OA with CARC 209 in place of CARCs 1 and 2, as well as CARCs 66, 247, and 248, on the ERAs and on SPRs, as applicable.

The shared systems shall include the revised alert RARCs N781 and N782 in association with CARCs 1 and/or 2 on the RA. These RARCs designate that the beneficiary is enrolled in the QMB program and may not be billed for Medicare cost sharing amounts. Additionally, for QMB claims, the Part A and B shared systems shall include the revised alert RARC N781 in association with CARC 66 (blood deductible). The revised alert RARCs are as follows:

- N781 - Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
- N782 – Alert: Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.

CR 9911 changes to the MSN by including QMB messages and reflecting $0 cost-sharing liability for the period beneficiaries are enrolled in QMB.

Additional information

The official instruction, CR 10433, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3993CP.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
March 13, 2018	This article was revised to reflect an updated CR. That CR added CARCs 66, 247, and 248. DME MACs were added to the *Providers affected* section and the QMB enrollment numbers were also updated under *Background* to reflect 2016 statistics. Pharmacies were also included in *Background*. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged.
February 28, 2018	This article was revised to correct a date in the *What you need to know* Section. The date should have been December 8, 2017." All other information is unchanged.
February 2, 2018	Initial article released.

MLN Matters® Number: MM10433
Related CR Release Date: March 6, 2018
Related CR Transmittal Number: R3993CP
Related Change Request (CR) Number: 10433
Effective Date: July 1, 2018
Implementation Date: For claims processed on or after July 2, 2018

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

Prohibition on billing dually eligible individuals enrolled in the QMB program

Note**: This article was revised March 22, 2018, to include updated information about the remittance advice (RA) and Medicare summary notice (MSN) for all Medicare fee-for-service (FFS) QMB claims. It also includes new statistics on the number of beneficiaries enrolled in QMB. All other information remains the same. This information was last published in the December 2017 Medicare A Connection, pages 4-7.* ***Note: Editorial corrections made May 23, 2018, to correct release date of revised article and correct verbiage and links in the "Background" and "Additional information" sections.

Provider types affected

This article pertains to all Medicare providers and suppliers, including pharmacies that serve beneficiaries enrolled in original Medicare or a Medicare advantage (MA) plan.

Provider action needed

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

Implement key measures to ensure compliance with QMB billing requirements. Use HIPAA eligibility transaction system (HETS) (effective November 2017), CMS' eligibility-verification system, and the provider RA (July 2018) to identify beneficiaries' QMB status and exemption from cost-sharing prior to billing. Starting July 2018, look for QMB alerts messages in the remittance advice for FFS claims to verify QMB after claim processing. Refer to the *Background* and *Additional information* sections for further details and important steps to promote compliance.

Background

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

Billing of QMBs is prohibited by federal law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a state Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

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

Note that certain types of providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt. For more information about bad debt, refer to Chapter 3 of the *Provider Reimbursement Manual* (Pub.15-1).

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

Inappropriate billing of QMB individuals persists

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

Ways to promote compliance with QMB billing rules

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

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.
    - Use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS' HETS (effective November 2017) to verify a beneficiary's QMB status and exemption from cost-sharing charges. Ask your third party eligibility-verification vendors how their products reflect the new QMB information from HETS. For more information on HETS, visit *https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html*.

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- In July 2018, CMS will reintroduce QMB information in the Medicare RA that original Medicare providers and suppliers can use to identify the QMB status of beneficiaries. Refer to the *Additional information* section for educational materials on recent changes that impact RAs for Medicare FFS QMB claims.
- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members both before and after claims submission.

2. Providers and suppliers may also verify beneficiaries' QMB status through state online Medicaid eligibility systems in the state in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card or documentation of their QMB status. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.
3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the states in which the beneficiaries you serve reside. Different processes may apply to original Medicare and MA services provided to individuals enrolled in the QMB program. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.
    - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.

States require all providers, including Medicare providers, to enroll in their Medicaid system for provider claims review, processing, and issuance of the Medicaid RA. Providers should contact the state Medicaid agency for additional information regarding Medicaid provider enrollment.

Important reminders concerning QMB billing requirements

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

1. All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must not charge individuals enrolled in the QMB program for Medicare cost-sharing.
2. Individuals enrolled in the QMB program keep their protection from billing when they cross state lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is from a different state than the state where they get care.
3. Note that individuals enrolled in QMB **cannot** elect to pay Medicare deductibles, coinsurance, and copays. However, a QMB who also receives full Medicaid may have a small Medicaid copay.

Additional information

For more information on this process, refer to Section HI 00801.140 of the *Social Security Administration Program Operations Manual System*.

Refer to these educational materials for information on recent changes that impact RAs and MSNs for Medicare FFS QMB claims:

- *MLN Matters® article MM9911*, discusses the claim processing system modifications implemented October 2, 2017, to generate QMB information in the RAs and MSNs.
- On December 8, 2017, the claim processing system modifications made October 2, 2017, were temporarily suspended due to unintended issues that affected processing QMB cost-sharing claims by states and other payers secondary to Medicare. For more information, refer to *QMB remittance advice issue*.
- *MLN Matters® article 10494* describes how Medicare administrative contractors (MACs) will issue replacement RAs for QMB claims paid on or after October 2, 2017, through December 31, 2017, that have not been voided or replaced. MACs will issue replacement RAs by December 20, 2018, for Part B claims and by September 20, 2018, for Part A/durable medical equipment claims.
- *MLN Matters® article MM10433* discusses how CMS will reintroduce QMB information in the RA starting July 2018 and modify to CR 9911 to avoid disrupting claim processing by secondary payers.

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

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Document history

Date of change	Description
March 22, 2018	The article was revised to indicate that CMS will reintroduce QMB information in the Medicare remittance advice (RA) and Medicare summary notice (MSN) for all claims processed on or after July 2, 2018. CMS initially included QMB information in RAs and MSNs for claims processed on or after October 2, 2017, but suspended those changes December 8, 2017, to address unforeseen issues preventing the processing of QMB cost-sharing claims by states and other secondary payers outside of the coordination of benefits agreement (COBA) process. All other information remains the same.
December 4, 2017	The article was revised to indicate that December 8, 2017, CMS will suspend modifications to the provider remittance advice and the Medicare summary notice for QMB claims made October 2, 2017. The article was also revised to show the HETS QMB release was implemented in November 2017. Finally, the article was changed to clarify that QMBs cannot elect to pay Medicare cost-sharing but may need to pay a small Medicaid copay in certain circumstances. All other information remains the same.
November 3, 2017	Article revised to show the HETS QMB release will be in November 2017. All other information remains the same.
October 18, 2017	The article was revised to indicate that the provider remittance advice and the Medicare summary notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.
August 23, 2017	The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.
May 12, 2017	This article was revised May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.
January 12, 2017	This article was revised to add a reference to *MLN Matters*® article *MM9817*, which instructs Medicare administrative contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.
February 4, 2016	The article was revised February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under *Important Clarifications Concerning QMB Balance Billing Law*.
February 1, 2016	The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table.
March 28, 2014	The article was revised to change the name of the coordination of benefits contractor (COBC) to BCRC.

MLN Matters® Number: SE1128 *Revised*
Related Change Request (CR) #: N/A
Release Date of Revised Article: March 22, 2018
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

Search capability simplifies LCD lookup

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

Providers can 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 previously 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

Bone mineral density studies – revision to the Part A and Part B LCD

LCD ID number: L36356 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10473 (ICD-10 and Other Coding Revisions to National Coverage Determination [NCDs]), the bone mineral density studies local coverage determination (LCD) was revised to add ICD-10-CM diagnosis code Z79.811* for *Current Procedural Terminology* (CPT®) codes 77080 and 77085. In addition, based on CR 8691, this LCD was revised to add ICD-10-CM diagnosis codes E34.2 and N95.9 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS)/CPT® codes G0130, 77078, 77080, 77081, 77085, and 76977.

Effective date

The LCD revision related to CR 10473 is effective for claims processed **on or after April 2, 2018**, for services rendered **on or after October 1, 2015**.

The LCD revision related to CR 8691 is effective for services rendered **on or after October 1, 2015**.

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*.

Diagnostic colonoscopy – revision to Part A and Part B LCD

LCD ID number: L33671 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an external inquiry the local coverage determination (LCD) for diagnostic colonoscopy was revised to remove ICD-10-CM diagnosis codes Z12.10, Z12.11, Z12.13, Z80.0, Z83.71 - Z83.79, Z85.038, Z85.048, and Z86.010 from the "ICD-10 Codes that Support Medical Necessity" section of the LCD. We want to clarify that these ICD-10-CM diagnoses are not appropriate for billing with a diagnostic colonoscopy *Current Procedural Terminology* (CPT®) code. For coding purposes a screening colonoscopy must be coded as Healthcare Common Procedure Coding System (HCPCS) codes G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) or G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk). For screening colonoscopies, please refer to First Coast Service Options Inc. colorectal cancer screening LCD (L36355).

Effective date

This LCD revision is effective for services rendered **on or after May 17, 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, please *click here*.

Medicare A Connection subscription

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

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

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

Fundus photography – revision to Part A and Part B LCD

LCD ID number: L33670 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the fundus photography local coverage determination (LCD), it was determined that the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, this LCD is being revised to assure consistency with the CMS manual language.

Effective date

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

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 an annual review the local coverage determination (LCD)/"coding guidelines" article for luteinizing hormone-releasing hormone (LHRH) analogs was revised to update the dosage information for Healthcare Common Procedure Coding System (HCPCS) code J3315 (triptorelin pamoate). Also, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after March 15, 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*.

Noncovered services – revision to Part A and Part B LCD

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

The local coverage determination (LCD) for noncovered services was revised based on an LCD reconsideration request. The quality of the evidence reviewed for the peri-prostatic transperineal placement of a hydrogel biodegradable material was strong for establishing that it resulted in a reduction of radiation dose delivered to the anterior rectum and that it is a safe, low risk procedure. In conclusion, for being a low risk procedure that could have theoretical benefits for beneficiaries, the Jurisdiction N (JN) Medicare Administrative Contractor (MAC) made the determination to remove Current Procedural Terminology (CPT®) code 55874 from the "CPT®/HCPCS Codes – Group 1 Codes:" under the subtitle "Procedures for Part A and Part B" section of the LCD, and Healthcare Common Procedure Coding System (HCPCS) code L8699 (Prosthetic implant, not otherwise specified [when used for hydrogel application of a spacer to increase the distance between the prostate and anterior rectal wall]) was removed from the "CPT®/HCPCS Codes – Group 5 Paragraph/Codes:" under the subtitle "Procedures for Part B only" section of the LCD. Removal of a service or procedure from the Noncovered Services LCD is not a positive coverage statement. Claims for such services assuming all other requirements of the program are met would always need to meet the medically reasonable and necessary threshold for coverage.

Effective date

The LCD revision is effective for services rendered **on or after March 8, 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*.

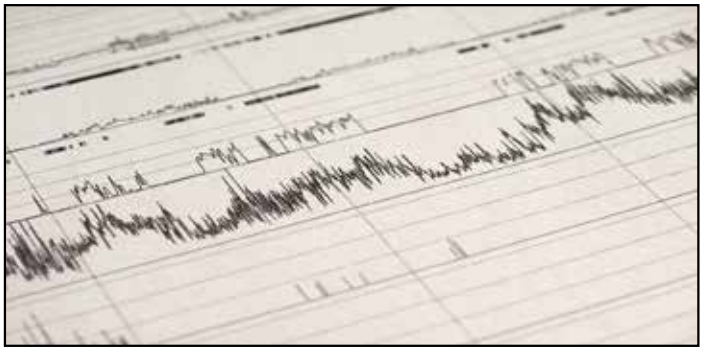
Polysomnography and sleep testing – revision to the Part A and Part B LCD

LCD ID number: L33405 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for polysomnography and sleep testing, it was determined that some of the italicized language throughout 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

The revision of this LCD is effective for services rendered **on or after March 15, 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*.

Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – revision to the Part A and Part B LCD

LCD ID number: L33538 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the radiation therapy for T1 basal cell and squamous cell carcinomas of the skin local coverage determination (LCD), it was determined that the italicized language in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, this LCD is being revised to assure consistency with the CMS manual language.

Effective date

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

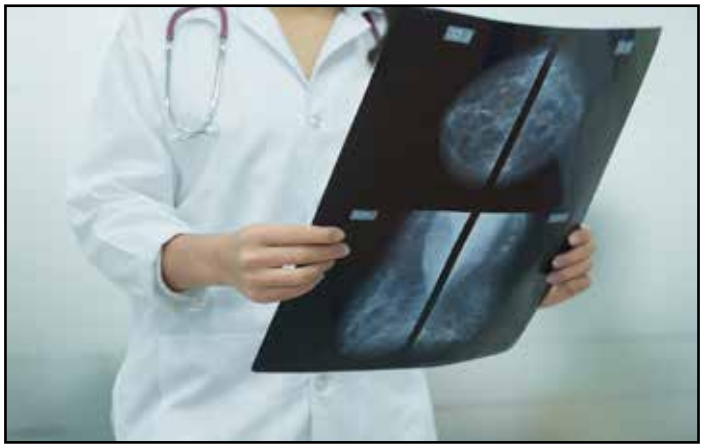
Looking for LCDs?

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.

Screening and diagnostic mammography – revision to the Part A and Part B coding guidelines article (A54846)

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

Based on an annual review of the screening and diagnostic mammography local coverage determination (LCD) coding guidelines article, it was determined that the italicized language does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD. Therefore, the coding guidelines article is being revised to assure consistency with the CMS manual language.



Effective date

This revision to the LCD coding guidelines article is effective for services rendered **on or after March 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*.

Surgical management of morbid obesity – revision to the Part A and Part B LCD

LCD ID number: L33411 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for surgical management of morbid obesity, it was determined that some of the italicized language throughout 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

The revision of this LCD is effective for services rendered **on or after March 15, 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*.

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Therapy and rehabilitation services – revision to the Part A and Part B LCD

LCD ID number: L33413 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for therapy and rehabilitation services was revised based on Section 50202 of the Bipartisan Budget Act, which repeals Medicare provisions affecting the outpatient therapy caps. This section requires that Medicare claims no longer be subject to the therapy cap. Therefore, the "Indications and Limitations of Coverage and/or Medical Necessity," "CPT®/HCPCS Codes," and "ICD-10 Codes that Support Medical Necessity" sections of the LCD were revised to remove language related to the therapy cap. Also, based on the Centers for Medicare and Medicaid Services (CMS) change request (CR) 10318 (national coverage determination (NCD) 270.1), the LCD was revised to add non-pressure chronic ulcers as covered for Healthcare Common Procedure Coding System (HCPCS) code G0281 in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Effective date

The LCD revision based on Section 50202 of the Bipartisan Budget Act is effective for claims processed **on or after February 23, 2018**, for services rendered **on after January 1, 2018**. The LCD revision based on CR 10318 is effective for claims processed **on or after April 2, 2018,** 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*.

Additional Information

Clarification on the implementation of change request (CR) 10318, transmittal 2005 titled, "ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs)"

The Centers for Medicare & Medicaid Services (CMS) has received multiple inquiries related to instructions in change request (CR) 10318 for national coverage determinations (NCDs) 110.21 and 80.11 and wants to clarify as follows.

CR 10318, transmittal 2005 titled, "ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs)" that was released January 18, 2018 (a correction to the initial CR 10318, transmittal 1975, dated November 9, 2017), contains the latest coding instructions to the CMS NCDs. Business requirement (BR) 10 specifically addresses coding changes for NCD 110.21 (Erythropoiesis Stimulating Agents (ESAs) in Cancer) and BR 21-21.2 specifically address coding changes for NCD 80.11 (Vitrectomy).

CMS is in the process of re-reviewing the coding changes for NCD 110.21. Until this review is complete and CMS makes a final determination, the A/B Medicare administrative contractors (MACs) will not implement the edits contained in CR 10318. The A/B MACs will also reprocess any claims that were processed in error from January 1, 2018 to the present, that were processed with the additional codes included in CR 10318 as not payable with the EC modifier.

Regarding the vitrectomy NCD (see *NCD Manual* Section 80.11) implementation instructions to remove certain diagnosis codes per CR 10318, CMS instructs the A/B MACs to not implement this editing. The CMS carefully reviews all coding revisions. While the review of the Vitrectomy NCD is no exception, CMS realizes that a large number of diagnosis codes were removed and that has caused some concern among stakeholders. We appreciate all the stakeholders' comments that notified CMS of the effect of the coding changes. As a result, CMS is in the process of a subsequent review of the codes marked for removal in CR 10318.

In the interim, codes included in the covered diagnosis list prior to CR 10318 are coverable. The CMS MACs have been notified of this decision. Any claims you and/or the MACs believe were processed in error as a result of CR 10318 will be reprocessed. Furthermore, if you were advised by a MAC to hold NCD 80.11 claims until further notice, please be assured you can submit those claims and they will be processed without regard to CR 10318.

Once CMS has completed their re-review of coding for NCD 80.11 and if changes to CR 10318 are warranted, they will release a subsequent CR as well as directions to its MACs indicating that decision, complete with specific implementation instructions.

April 2018 integrated outpatient code editor specifications version 19.1

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) 10514 provides the integrated outpatient code editor (I/OCE) instructions and specifications for the I/OCE that will be used in the outpatient prospective payment system (OPPS) and non-OPPS for hospital inpatient departments, community mental health centers (CMHCs), all non-OPPS providers, and for limited services when provided in a home health agency not under the home health prospective payment system (HH PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these updates.

Background

CR 10514 informs the MACs, including the home health and hospice (HH&H MAC) and the fiscal intermediary shared system (FISS), that the I/OCE is being updated for April 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The I/OCE specifications are available at *https://www.cms.gov/OutpatientCodeEdit/*.

The following table summarizes the modifications of the I/OCE for the April 2018 V19.1 update. Readers should also read through the entire CR 10514 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	Modifications
1/1/2018		Update the program to remove the logic that assigns HCPCS level modifier V3 to the line level output for OPPS claims submitted with drug HCPCS lines with status indicator (SI) = K that are reported with modifier JG.
4/1/2018	72	Implement program logic to bypass edit 72 when a HCPCS is present from a specified list for rural health clinic (RHC) and federally qualified health center (FQHC) claims (see quarterly data files for HCPCS subject to edit 72 bypass).
4/1/2018	104	Implement new edit 104: Service not eligible for all-inclusive rate (LIR). **Edit criteria**: RHC claim with bill type 71x contains a line reported with modifier CG that is not eligible for the RHC all-inclusive rate.
7/1/2017	105	Implement new edit 105: Claim reported with pass-through device prior to FDA approval for procedure (LID). **Edit criteria**: A procedure is reported with a pass-through device prior to the FDA approval date for the procedure paired with the device. The line item denial is returned on the device line.
4/1/2018	106	Implement new edit 106: Add-on code reported without required primary procedure code (LID). **Edit criteria**: A Type I add-on code is reported on a non-OPPS claim without any of its defined primary codes. The disposition is set to line item denial and is applied to the line with the add-on code.
4/1/2018	107	Implement new edit 107: Add-on code reported without required contractor-defined primary procedure code (LID). **Edit criteria**: A Type II add-on code is reported on a non-OPPS claim without any primary code from the contractor-defined list. The disposition is set to line item denial and is applied to the line with the add-on code.
4/1/2018	108	Implement new edit 108: Add-on code reported without required primary procedure or without required contractor-defined primary procedure code (LID). **Edit criteria**: A Type III add-on code is reported on a non-OPPS without any of its defined primary codes, or without any of the primary codes from the contractor-defined list. The disposition is set to line item denial and is applied to the line with the add-on code.

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Effective date	Edits affected	Modifications
4/1/2018	22	Add the following new modifiers to the valid modifier list: ▪ VM: Mdpp virtual make-up session ▪ QA: Avg sta day/night o2 < 1 lpm ▪ QB: Avg day/nite o2 > 4 lpm/port ▪ QR: Avg sta day/night o2 > 4lpm
4/1/2018	94, 103	Update the program logic to deactivate edits 94 and 103 associated with the reporting of biosimilar HCPCS codes with manufacturer modifier. **Note**: biosimilar manufacturer modifiers ZA, ZB, and ZC are deleted.
4/1/2018		Update Section 6.1 of documentation (medical visit processing) to include additional examples of conditions for claims containing multiple medical visits. Note: no change to logic.
4/1/2018		Update Section 6.12 of documentation (special processing for drugs and biologicals) by removing the paragraph regarding the assignment of the HCPCS level modifier, V3 for HCPCS with SI=K.
4/1/2018		Update the following lists for the release (see quarterly data files) ▪ HCPCS modifier list ▪ Biosimilar HCPCS list ▪ Complexity-adjusted comprehensive ambulatory payment classification (APC) code pairs ▪ Skin substitute products (edit 87) ▪ Device offset code pairs (Mid-Quarter effective date 8/25/17) ▪ Add on type I (new code list for edit 106) ▪ Add on type II (new code list for edit 107) ▪ Add on type III (new code list for edit 108) ▪ FQHC/RHC bypass edit 72 (new code list) ▪ RHC CG modifier not payable list (new code list) ▪ Services not recognized under OPPS (edit 62) ▪ Services reportable to DMERC (edit 61) ▪ Services not billable to the MAC (edit 72)

Effective date	Edits affected	Modifications
4/1/2018		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files)
4/1/2018	20, 40	Implement version 24.1 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers)

Additional information

The official instruction, CR 10514, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4006CP.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
March 22, 2018	This article was revised to reflect an updated CR that updated the status indicator for the drug code J0606 from SI=G to SI=K in the attachments. All other information remains the same.
March 6, 2018	Initial article released.

MLN Matters® Number: MM10514
Related CR Release Date: March 21, 2018
Related CR Transmittal Number: R4006CP
Related Change Request (CR) Number: 10480
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

Billing requirements for OPPS providers with multiple service locations

Note: Editorial corrections made May 23, 2018, to the related CR number and implementation date.

Provider type affected

This *MLN Matters*® special edition article is intended for outpatient prospective payment system (OPPS) providers that have multiple service locations submitting claims to Medicare A/B Medicare administrative contractors (MACs).

What you need to know

This article conveys enforcement editing requirements for the *Medicare Claims Processing Manual*, Chapter 1, and Section 170 which describes payment bases for institutional claims. These requirements are not new requirements. Previously, these requirements were discussed in CRs 9613 and 9907, both of which were effective January 1, 2017. *MLN Matters*® articles for CRs 9613 and 9907 are available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9613.pdf* and *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9907.pdf*, respectively. Make sure your billing staff is aware of these instructions.

Background

Increasingly, hospitals operate off-campus, outpatient, provider-based department of a hospital's facilities. In some cases, these additional locations are in a different payment locality than the main provider. In order for Medicare physician fee schedule (MPFS) and OPPS payments to be accurate, the service facility address of the off-campus, outpatient, provider-based department of a hospital facility is used to determine the locality in these cases.

Additionally, in accordance with Section 1833(t)(21) of the Act, as added by Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), Non-excepted services provided at an off- campus, outpatient, provider-based department of a hospital were required to be identified as non-excepted items and services billed on an institutional claim and to be paid under the MPFS and not the OPPS rates.

Claim level information:

Medicare outpatient service providers report the service facility location for off-campus, outpatient, provider-based department of hospital facilities in the 2310E loop of the 837 institutional claim transactions. Direct data entry (DDE) submitters also are required to report the service facility location for off-campus, outpatient, provider-based department of hospital facilities. Paper submitters report the service facility address information in Form Locator (FL) "01" on the paper claim form. For MPFS services, Medicare systems use this service facility information to determine the applicable payment method or locality whenever it is present.

Additionally, Medicare systems will validate service facility location to ensure services are being provided in a Medicare-enrolled location. The validation will be exact matching based on the information submitted on the form CMS-855A submitted by the provider and entered into the provider enrollment, chain and ownership system (PECOS). Providers need to ensure that the claims data matches their provider enrollment information.

When all the services rendered on the claim are from the billing provider address, providers are:

- To report the billing provider address only in the billing provider loop and not to report any service facility location.

When all the services rendered on the claim are from one campus of a multi-campus provider that report a billing provider address, providers are:

- To report the campus address where the services were rendered in the service facility location if the service facility address is different from the billing provider address.

When all the services rendered on the claim are from the same off-campus, outpatient, provider-based department of a hospital facilities, providers are:

- To report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop.

When there are services rendered on the claim from multiple locations:

- If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E.
- If no services on the claim were rendered at the billing provider address, providers should report the service facility address from the first registered encounter of the "From" date on the claim.

NM1 - SERVICE FACILITY LOCATION NAME – 60 Characters 837I – 25, UB-04

N3 - SERVICE FACILITY LOCATION ADDRESS

N301 – 55 Characters 837I – 25 characters on the UB-04

N302 – 55 Characters 837I – not on UB-04 paper form

N4 - SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE

N401 City Name – 30 Characters 837I – 12 characters on the UB-04

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N402 State Code – 2 Characters 837I – 2 characters on the UB-04

N403 Postal Code – 15 Characters 837I – 9 characters on the UB-04

Line level information:

In the 2015 OPPS final rule (79 FR 66910-66914), the Centers for Medicare & Medicaid Services (CMS) created a HCPCS modifier for hospital claims that is to be reported with each claim line with a HCPCS for outpatient hospital items and services furnished in an off-campus provider-based department (PBD) of a hospital. This two-digit modifier was added to the HCPCS annual file as of January 1, 2015, with the label "PO." Reporting of this new modifier was voluntary for CY 2015, with reporting required beginning January 1, 2016. In accordance with Section 1833(t)(21) of the Act, as added by Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS established a new modifier "PN" (Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital) to identify and pay non-excepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line with a HCPCS for non-excepted items and services. The use of modifier "PN" will trigger a payment rate under the MPFS. CMS expects the PN modifier to be reported with each non-excepted line item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services; with reporting required beginning January 1, 2017.

As a result, effective January 1, 2017, excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO" (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services with a HCPCS furnished. **Note**: Billing examples are provided on page 19.

Additional information

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

You may also want to review relevant portions of *MLN Matters*® articles MM9097 and MM9930 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9097.pdf* and *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9930.pdf*, respectively.

Document history

Date of change	Description
March 15, 2018	Initial article released.

MLN Matters® Number: SE18002
Related CR Release Date: August 5, 2016; February 5, 2017
Related CR Transmittal Number: R1704OTN and R1783OTN
Related Change Request (CR) Number: 9613; 9907
Effective Date: January 1, 2018
Implementation Date: January 3, 2017, for CR 9613 and July 3, 2017, for CR 9907

See **BILLING**, page 19

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.

BILLING

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Billing examples

No.	Service facility	Billing provider	Service facility address	Modifier used
1	Billing provider (main campus) only	Yes	N/A	No “PO” or “PN” modifier required on billing provider services.
2	Billing provider (main campus), excepted off-campus	Yes	N/A	No “PO” or “PN” modifier required on main campus services. **Modifier “PO” required on services with a HCPCS from excepted off-campus.**
3	Billing provider (main campus), non-excepted off-campus	Yes	N/A	No “PO” or “PN” modifier required on main campus services. **Modifier “PN” required on services with a HCPCS from non-excepted off-campus.**
4	Billing provider (main campus), campus of multi-campus provider*	Yes	N/A	No “PO” or “PN” modifier required on billing provider services or other campus services of a multi-campus.
5	Campus of multi-campus provider*	Yes	Yes campus address*	No “PO” or “PN” modifier required on billing campus services of a multi-campus.
6	Billing provider (main campus), excepted off-campus, non-excepted off-campus	Yes	N/A	No “PO” or “PN” modifier required on billing provider services. Modifier “PO” required on services with a HCPCS from excepted off-campus. **Modifier “PN” required on services with a HCPCS from non-excepted off-campus.**
7	Billing provider (main campus), campus of multi-campus provider*, excepted off-campus, non-excepted off-campus	Yes	N/A	No “PO” or “PN” modifier required on billing provider services or other campus services of a multi-campus. **Modifier “PO” required on services with a HCPCS from excepted off-campus**. Modifier “PN” required on services with a HCPCS from non-excepted off-campus.
8	Campus of multi-campus provider*, excepted off-campus, non-excepted off-campus	Yes	Yes campus address*	No “PO” or “PN” modifier required on billing campus services of a multi-campus. **Modifier “PO” required on services with a HCPCS from excepted off-campus.** Modifier “PN” required on services with a HCPCS from non-excepted off-campus.
9	Excepted off-campus	Yes	Yes	Modifier “PO” required on all services with a HCPCS.
10	Non-excepted off-campus	Yes	Yes	Modifier “PN” required on all services with a HCPCS.
11	Excepted off-campus, non-excepted off-campus	Yes	Yes first registered encounter	Modifier “PO” required on services with a HCPCS from excepted off-campus. **Modifier “PN” required on services with a HCPCS from non-excepted off-campus.**
12	Excepted off-campus, excepted off-campus	Yes	Yes first registered encounter	Modifier “PO” required on all services with a HCPCS.
13	Non-excepted off-campus, non-excepted off-campus	Yes	Yes first registered encounter	Modifier “PN” required on all services with a HCPCS.

* Campus address is different from billing provider address; if the campus address is the same as the billing provider address, follow the billing provider instructions.

Diagnosis code update for add-on payments for blood clotting factor administered to hemophilia inpatients

Provider type affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare administration contractors (MACs) for inpatient services to Medicare beneficiaries with hemophilia.

What you need to know

Change request (CR) 10474 provides updates to diagnosis codes required in order to allow add-on payments under the inpatient prospective payment system (IPPS) for blood clotting factor administered to hemophilia inpatients. The add-on payment criteria for blood clotting factors administered to hemophilia inpatients will be updated July 1, 2018, by terminating International Classification of Diseases, Clinical Modification (ICD-CM) code D68.32, effective with that date. The list of ICD-CM codes that will continue to receive the add-on payment can be found in Section 20.7.3, of Chapter 3 of the *Medicare Claims Processing Manual*. Make sure your billing staffs are aware of this update.

Background

The September 1, 1993, IPPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if an ICD-CM diagnosis code for hemophilia is included on the bill.

Effective July 1, 2018, code D68.32 (antiphospholipid antibody with hemorrhagic disorder) is **terminated**. Therefore, providers that include diagnosis code D68.32 on inpatient claims with discharge dates after July 1, 2018, will not receive the add-on payment.

Additional information

The official instruction, MM10474, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3990CP.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
March 2, 2018	This article was revised to reflect the revised CR 10474 issued March 1. 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.
February 9, 2018	Initial article released.

MLN Matters® Number: MM10474
Related CR Release Date: March 1, 2018
Related CR Transmittal Number: R3990CP
Related Change Request (CR) Number: 104874
Effective Date: July 1, 2018
Implementation Date: July 2, 2018

Manual updates to Pub. 100-01, 100-02 and 100-04 to correct errors and omissions

Provider type affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 10512 which informs MACs about an update to the Medicare manuals to correct various minor technical errors and omissions. Those changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

Go – what you need to do

Make sure that your billing staff are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 10512 updates the Medicare manuals with regard to SNF policy to clarify the existing content. These changes are being made to correct various omissions and minor technical errors. No policy, processing or system changes are anticipated.

Medicare General Information, Eligibility and Entitlement Manual,

Chapter 4: Physician Certification and Recertification of Services

Pub 100-01, Chapter 4, §40.1

This section is revised by adding an appropriate cross-reference.

Pub 100-01, Chapter 4, §40.2

This section is revised by clarifying the discussion of the initial certification's required content, and by adding an appropriate cross-reference.

Chapter 5: Medicare General Information, Eligibility, and Entitlement

Pub 100-01, Chapter 5, §30.2

This section is revised by updating the existing citation to the regulations at 42 CFR 483.75(n), in order to reflect their redesignation at 42 CFR 483.70(j) in the long-term care facility requirements reform final rule (81 FR 68831, October 4, 2016).

Pub 100-01, Chapter 5, §30.3

This section is revised by updating the existing citation to the regulations at 42 CFR 482.66, in order to reflect their redesignation at 42 CFR 482.58 in a final rule that was published on May 12, 2014 (79 FR 27155), and by adding an appropriate cross-reference.

Medicare Benefit Policy Manual

Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance

Pub 100-02, Chapter 8, §20.2.3

This section is revised by modifying the language that describes the starting point of the applicable 30-day period, so that it more accurately tracks that of the corresponding statutory authority in §1861(i) of the Social Security Act and the implementing regulations at 42 CFR 409.36.

Pub 100-02, Chapter 8, §30.1

This section is revised by modifying the language so that it no longer pertains to only one particular type of case-mix model, and by adding a reference to the posting of the CMS-designated case-mix classifiers on the SNF PPS web site. These changes reflect similar revisions made in the corresponding regulations at 42 CFR 409.30 and 413.345 by the FY 2018 SNF PPS final rule (82 FR 35644-45, August 4, 2017).

Pub 100-02, Chapter 8, §40.1

This section is revised by updating the existing citation to the regulations at 42 CFR 483.40(e), in order to reflect their redesignation at 42 CFR 483.30(e) in the long-term care facility requirements reform final rule (81 FR 68829, October 4, 2016).

Pub 100-02, Chapter 8, §50.3

This section is revised to correct some cross-references, and to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-02, Chapter 8, §50.8.2

This section is revised to correct a cross-reference.

Pub 100-02, Chapter 8, §70.4

The first paragraph of this section is revised to clarify the scope of services for which SNFs can make arrangements with outside sources, and also by adding an appropriate cross-reference.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Pub 100-04, Chapter 1, §30.1.1.1

This section is revised by updating the existing citation to the regulations at 42 CFR 483.10(b)(5)-(6), in order to reflect their revision and redesignation at 42 CFR 483.10(g)(17)-(18) in the long-term care facility requirements reform final rule (81 FR 68825, 68854, October 4, 2016).

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BILLING

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Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

Pub 100-04, Chapter 6, §10.1

This section is revised to expand and clarify the discussion of a beneficiary's status as a SNF "resident" for consolidated billing purposes to conform more closely with the corresponding regulations at 42 CFR 411.15(p)(3), as well as by adding some appropriate cross-references, and by updating the existing citation to the regulations at 42 CFR 483.12(a)(2)(i)-(vi), in order to reflect their redesignation at 42 CFR 483.15(c)(1)(i)(A)-(F) in the long-term care facility requirements reform final rule (81 FR 68826, October 4, 2016).

Pub 100-04, Chapter 6, §10.4

This section is revised by updating the existing citation to the regulations at 42 CFR 483.75(h), in order to reflect their redesignation at 42 CFR 483.70(g) in the long-term care facility requirements reform final rule (81 FR 68830, October 4, 2016).

Pub 100-04, Chapter 6, §20.1.2

This section is revised to restore a minor edit that was agreed to during the internal review of CR 9748 but was then inadvertently omitted from the published version.

Pub 100-04, Chapter 6, §20.2.1

The final paragraph of this section is revised to reflect the statutory addition of acute dialysis to the scope of the Part B dialysis benefit and, by extension, to the scope of the dialysis exclusion from SNF consolidated billing as well.

Pub 100-04, Chapter 6, §20.3

This section is revised to clarify the language in a parenthetical phrase.

Pub 100-04, Chapter 6, §20.3.1

This section is revised to clarify that the exclusion of dialysis-related ambulance transports from SNF consolidated billing applies to the entire ambulance roundtrip from the SNF, and to clarify the discussion of a beneficiary's status as a SNF "resident" for consolidated billing purposes. In addition, the existing citation to the regulations at 42 CFR 483.10(b)(6) is updated in order to reflect their revision and redesignation at 42 CFR 483.10(g)(18) in the long-term care facility requirements reform final rule (81 FR 68825, 68854, October 4, 2016).

Pub 100-04, Chapter 6, §40.3.3

This section is revised to clarify the language on counting inpatient days.

Pub 100-04, Chapter 6, §40.3.4

This section is revised to clarify the language on counting inpatient days and the discussion of a beneficiary's status as a SNF "resident" for consolidated billing purposes.

Pub 100-04, Chapter 6, §40.3.5

This section is revised to clarify the language on counting inpatient days and the language that describes the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-04, Chapter 6, §40.3.5.2

This section is revised to clarify the language that describes the nonparticipating portion of the same institution that also includes a participating distinct part.

Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Pub 100-04, Chapter 20, §10.2

In column A ("Conditions"), a cross-reference in item 2 is corrected, and in column B ("Review Action"), the next-to-last paragraph in item 2 is revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Chapter 30 - Financial Liability Protections

Pub 100-04, Chapter 30, §130.3

Paragraphs A and B of this section are revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Pub 100-04, Chapter 30, §130.4

Paragraph A of this section is revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

Additional information

The official instruction, CR 10512, issued to your MAC regarding this change consists of the following three transmittals:

- Transmittal R114GI updates the *Medicare General Information, Eligibility, and Entitlement Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R114GI.pdf*.
- Transmittal R242BP updates the *Medicare Benefit Policy Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R242BP.pdf*.
- Transmittal R4001CP updates the *Medicare Claims Processing Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4001CP.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
March 16, 2018	Initial article released.

MLN Matters® Number: MM10512
Related CR Release Date: March 16, 2018
Related CR Transmittal Number: R114GI, R242BP, and R4001CP
Related Change Request (CR) Number: 10512
Effective Date: June 19, 2018
Implementation Date: June 19, 2018

Modifications to the implementation of the paperwork segment of the esMD system

Provider type affected

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

Provider action needed

Change request (CR) 10397 updates the business requirements to enable MACs to receive unsolicited documentation (also known as paperwork (PWK)) via the electronic submission of medical documentation (esMD) system. CR 10397 is for esMD purposes only. Please make sure your billing staffs are aware of these updates.

Background

CR 10397 also contains attachments that include cover sheets that must be used for electronic, fax, or mail submissions of documentation. There are three cover sheets, one each for Part A and Part B providers, as well as one for durable medical equipment (DME) suppliers. In addition, there are two companion guides attached to CR 10397, one for institutional claims and one for professional claims. A link to CR 10397 is available in the *Additional information* section of this article.

With CR 10397, MACs will modify PWK, also known as unsolicited documentation procedures to include electronic submission(s) via esMD. Also, Medicare systems will accept PWK 02 values "EL" and "FT" for those MACs in a CMS-approved esMD system. This mechanism will suppress initial auto letter generation, if applicable, when PWK 02 is "EL" or "FT," and is present at any level of the claim or line.

Providers will receive communication from MACs via companion documents for 5010 X12 837 to include:

- The value "EL" (electronic) in PWK 02 to represent an esMD submission for sending the documentation using X12 Standards (6020 X12 275)
- The value "FT" (file transfer) in PWK 02 to represent an esMD submission for sending the documentation in PDF format using XDR specifications.

MACs will allow seven calendar "waiting days" (from the date of receipt) for additional information to be submitted when the PWK 02 value is "EL" or "FT."

MACs will use RC client to reject the PWK data submissions as administrative error(s) when the received cover sheet (via esMD) is incomplete or incorrectly filled out as applicable to current edits. Providers can expect to see new generic reason statements introduced to convey these errors as follows (Codes for these statements will be finalized and sent along with the RC implementation guide):

- The date(s) of service on the cover sheet received is missing or invalid.
- The NPI on the cover sheet received is missing or invalid.
- The state where services were provided is missing or invalid on the cover sheet received.
- The Medicare ID on the cover sheet received is missing or invalid.
- The billed amount on the cover sheet received is missing or invalid.
- The contact phone number on the cover sheet received is missing or invalid.
- The beneficiary name on the cover sheet received is missing or invalid.
- The claim number on the cover sheet received is missing or invalid.
- The attachment control number (CAN) on the cover sheet is missing or invalid.

Once again, examples of the cover sheet are included as an attachment to CR 10397.

Additional information

The official instruction, CR 10397, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2031OTN.pdf*.

The X12 837 companion guides are available at *https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/CompanionGuides.html*.

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
February 16, 2018	Initial article released.

MLN Matters® Number: MM10397
Related CR Release Date: February 16, 2018
Related CR Transmittal Number: R2031OTN
Related Change Request (CR) Number: 10397
Effective Date: July 1, 2018
Implementation Date: July 2, 2018

April 2018 update to the healthcare provider taxonomy codes

Provider type affected

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

What you need to know

Change request (CR) 10402 directs MACs to obtain the most recent healthcare provider taxonomy codes (HPTCs) code set and use it to update their internal HPTC tables and/or reference files. Make sure your billing staffs are aware of these changes.

Background

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

You should note that:

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

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view or for download from the NUCC website at *https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40*.

Although the NUCC generally posts their updates on the WPC webpage 3 months prior to the effective date, changes are not effective until April 1 or October 1, as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the HCPT code set online, revisions made since the last release are identifiable by these color codes:

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

Additional information

The official instruction, MM10402, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2018Downloads/R3977CP.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
February 16, 2018	Initial article released.

MLN Matters® Number: MM10402
Related Change Request (CR) Number: 10402
Related CR Release Date: February 16, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R3977CP
Implementation Date: July 2, 2018

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

Provider type affected

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

What you need to know

Change request (CR) 10489 updates the remittance advice remark codes (RARC) and claims adjustment reason code (CARC) lists and instructs Medicare shared system maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staff are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA, using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1. This recurring update notification applies to Chapter 22, Sections 40.5, 60.1, and 60.2 of the *Medicare Claims Processing Manual*."

The shared system maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 10489, MACs must implement on the date specified on the WPC website, available at: *https://wpc-edi.com/Reference/*.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update, CR 10270 (see *MLN Matters*® article *MM10270*).

Additional information

The official instruction, CR 10489, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3980CP.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
February 16, 2018	Initial article released.

MLN Matters® Number: MM10489
Related Change Request (CR) Number: 10489
Related CR Release Date: February 16, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R3980CP
Implementation Date: July 2, 2018

MSI reminder announcement: There is still time to evaluate our services

There is still time to share your experiences about the services we provide. Please complete the MAC Satisfaction Indicator (MSI) survey. These survey results will help us find ways to better serve you. *https://cfigroup.qualtrics.com/jfe/form/SV_0iaaiJ6oOWShLIF?MAC_BRNC=9&MAC=JN–First_Coast*

April 2018 update of the hospital outpatient prospective payment system

Note: Editorial corrections made May 23, 2018, to link to change request (CR).

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

CR 10515 describes changes to the OPPS to be implemented in the April 2018 update. Make sure your billing staffs are aware of these changes.

Background

The April 2018 integrated outpatient code editor (I/OCE) will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, status indicator (SI), and revenue code additions, changes, and deletions identified in CR 10515. The April 2018 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming April 2018 I/OCE CR.

An article for the April 2018 I/OCE is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10514.pdf*.

1. New separately payable procedure code

Effective April 1, 2018, HCPCS Code C9749 is added and is described in the following table.

New separately payable procedure code

Code	Short descriptor	Long descriptor	SI	APC	OPPS payment rate
C9749	Repair nasal stenosis w/imp	Repair of nasal vestibular lateral wall stenosis with implant(s)	J1	5164	$2,199.06

2. Multianalyte assays with algorithmic analyses (MAAA) CPT® coding change effective January 1, 2018

The AMA CPT® editorial panel established one new MAAA code, specifically, 0011M, effective January 1, 2018. Because the code was released December 1, 2017, it was too late to include in the January 2018 OPPS update. Instead, this code is being included in the April 2018 update with an effective date of January 1, 2018. The following table lists the long descriptor and SI for CPT® code 0011M.

MAAA CPT® coding change effective January 1, 2018

CPT® code	Long descriptor	SI	OPPS APC
0011M	Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk	A	N/A

3. Proprietary laboratory analyses (PLA) CPT® coding changes effective January 1, 2018

The AMA CPT® editorial panel established 11 new PLA CPT® codes, specifically, CPT® codes 0024U through 0034U and deleted two PLA codes, specifically, CPT® codes 0004U and 0015U, effective January 1, 2018. Because the codes were released December 1, 2017, it was too late to include them in the January 2018 OPPS update. Instead, they are being including in the April 2018 update with an effective date of January 1, 2018.

The following table lists the long descriptors and status indicators for CPT® codes 0024U through 0034U. For more information on OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the 2018 OPPS/ASC final rule. CPT® codes 0024U through 0034U have been added to the April 2018 I/OCE with an effective date of January 1, 2018. These codes, along with their short descriptors and status indicators, are also listed in the April 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*.

Proprietary laboratory analyses (PLA) CPT® coding changes effective January 1, 2018

CPT® code	Long descriptor	OPPS SI	OPPS APC
0004U	Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate	D	N/A

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CPT® code	Long descriptor	OPPS SI	OPPS APC
0015U	Drug metabolism (adverse drug reactions), DNA, 22 drug metabolism and transporter genes, real-time PCR, blood or buccal swab, genotype and metabolizer status for therapeutic decision support	D	N/A
0024U	Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative	Q4	N/A
0025U	Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative	Q4	N/A
0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result (“Positive, high probability of malignancy” or “Negative, low probability of malignancy”)	A	N/A
0027U	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15	A	N/A
0028U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis	A	N/A
0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823)	A	N/A
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)	A	N/A
0031U	CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7)	A	N/A
0032U	COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant	A	N/A
0033U	HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.759C>T] and rs1414334 [c.551-3008C>G])	A	N/A
0034U	TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(eg, thiopurine metabolism), gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5)	A	N/A

4. Reassignment of skin substitute product from the low cost group to the high cost group

One skin substitute product, HCPCS code Q4180, has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The product is listed in the following table.

Reassignment of skin substitute product from the low cost group to the high cost group effective April 1, 2018

2018 HCPCS code	2018 short descriptor	2018 SI	Low/high cost skin substitute
Q4180	Revita, per sq cm	N	High

5. Drugs, biologicals, and radiopharmaceuticals

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

For 2018, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals that were not acquired through the 340B program is made at a single rate of ASP + 6 percent (or ASP -22.5 percent if acquired under the 340B program), which provides payment

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for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In 2018, a single payment of ASP + 6 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. Updated payment rates effective April 1, 2018, and drug price restatements can be found in the April 2018 update of the OPPS Addendum A and Addendum B at *https://www.cms.gov/Medicare/Medicare-Fee-for-Servicedden-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

b. Drugs and biologicals with OPPS pass-through status effective April 1, 2018

Eleven drugs and biologicals have been granted OPPS pass-through status effective April 1, 2018. These items, along with their descriptors and APC assignments, are identified in the following table.

Drugs and biologicals with OPPS pass-through status effective April 1, 2018

Code	Long descriptor	APC	Status indicator
C9462	Injection, delafloxacin, 1 mg	9462	G
C9463	Injection, aprepitant, 1 mg	9463	G
C9464	Injection, rolapitant, 0.5 mg	9464	G
C9465	Hyaluronan or derivative, Durolane, for intra-articular injection, per dose	9465	G
C9466	Injection, benralizumab, 1 mg	9466	G
C9467	Injection, rituximab and hyaluronidase, 10 mg	9467	G
C9468	Injection, factor ix (antihemophilic factor, recombinant), glycopegylated, Rebinyn, 1 i.u.	9468	G
C9469	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	9469	G
Q2040	Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	9081	G
Q2041	Axicabtagene Ciloleucel, up to 200 Million Autologous Anti-CD19 CAR T Cells, Including Leukapheresis And Dose Preparation Procedures, Per Infusion	9035	G
Q5104	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg	9036	G

c. 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 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.

d. Changes to biosimilar biological product HCPCS codes and modifiers

Effective April 1, 2018, CMS is revising the long and short descriptors for HCPCS code Q5101. The table on page 29 displays the revised descriptors.

In addition, effective April 1, 2018, HCPCS codes Q5103, Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg, and Q5104, Injection, infliximab-abda, biosimilar, (renflexis), 10 mg will replace HCPCS code Q5102, Inj., infliximab biosimilar. The table on page 29 describes coding changes, status indicator, APC assignments, and effective dates for biosimilar biological product HCPCS codes.

The new biosimilar payment policy also makes the use of modifiers that describe the manufacturer of a biosimilar product unnecessary. Therefore, modifiers ZA, ZB, and ZC will be discontinued for dates of service on or after April 1, 2018. However, please note that HCPCS code Q5102 and the requirement to use applicable biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.

6. Use of modifier FY

As stated in the 2018 OPPS/ASC final rule, section 502 of Division O, title V of the Consolidated Appropriations Act, 2016 (Pub. L. 114-113), which was enacted on December 18, 2015, contains provisions to incentivize the transition from traditional X-ray imaging to digital radiography. As permitted by Section 1833(t)(16)(F)(iv) of the Social Security Act (the Act), CMS implemented modifier FY (*X-ray taken using computed radiography technology/cassettebased imaging*) to enable providers under the OPPS to appropriately report computed radiography services. Effective January 1, 2018, hospital outpatient facilities are required to use this modifier with

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the applicable HCPCS code(s) to describe an imaging service that is an X-ray taken using computed radiography technology.

In this same final rule, CMS also stated that Section 1833(t)(16)(F)(ii) of the Act provides for a phased-in reduction in payment in the case of an imaging service that is an X-ray taken using computed radiography technology (as defined in section 1848(b)(9)(C) of the Act). Payment for such a service (including the X-ray component of a packaged service) furnished during 2018, 2019, 2020, 2021, or 2022, that would otherwise be determined under Section 1833(t) of the Act (without application of subparagraph (F)(ii) and before application of any other adjustment), will be reduced by 7 percent, and if such a service is furnished during 2023 or a subsequent year, by 10 percent. For purposes of this reduction, computed radiography technology is defined in Section 1848(b)(9)(C) of the Act as cassette-based imaging which utilizes an imaging plate to create the image involved.

CMS notes that Section 1833(t)(16)(F)(ii) refers to *an* imaging service that *is* an X-ray taken using computed radiography technology. Where the imaging service is comprised of multiple images that include both X-rays taken using computed radiography technology and images taken using digital radiography, CMS does not believe the payment reduction would apply to that service. Instead, the payment adjustment applies to an imaging service that is an X-ray taken using computed radiography technology where the X-ray taken using computed radiography technology is not combined with digital radiography in the same imaging service.

7. 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 10515, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4005CP.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/Monitorinnug-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date of change	Description
March 22, 2018	This article was revised to reflect an updated CR that updated the number of drugs and biologicals with OPPS pass-through status effective April 1, 2018, from twelve to eleven and to remove HCPCS code J0606, Injection, etelcalcetide, 0.1 mg, from Table 5, Attachment A in the CR since its status indicator remains "K" for the April update.
March 6, 2018	Initial article released.

MLN Matters® Number: MM10515
Related CR Release Date: March 20, 2018
Related CR Transmittal Number: R4005CP
Related Change Request (CR) Number: 10515
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

Changes to biosimilar biological product HCPCS codes

Code	Short descriptor	Long descriptor	APC	SI	Added date	Term date
Q5102	Inj., infliximab biosimilar	Injection, infliximab, biosimilar, 10 mg	1847	G	07/01/2016	03/31/2018
Q5103	Injection, inflectra	Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg	1847	G	04/01/2018	
Q5104	Injection, renflexis	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg	9036	G	04/01/2018	

Revised descriptors for Q5101

Code	Short descriptor	Long descriptor	APC	SI	Added date
Q5101	Injection, zarxio	Injection, filgrastimsndz, biosimilar, (zarxio), 1 microgram	1822	G	07/01/2015

SSI Medicare beneficiary data for FY 2016 for IPPS hospitals, IRFs, and long-term care hospitals

Note: Editorial corrections made May 23, 2018, to the related CR release date.

Provider type affected

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

Provider action needed

Change request (CR) 10527 informs MACs about updated data for determining the disproportionate share adjustment for IPPS hospitals and the low-income patient adjustment for IRFs, as well as payments, as applicable, for LTCH discharges (for example, discharges paid the IPPS comparable amount under the short-stay outlier payment adjustment). Make sure that your billing staffs are aware of these changes.

Under the LTCH PPS, the payment adjustment for short-stay outlier (SSO) cases at 42 CFR 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (that is, the "IPPS comparable amount."). This calculation includes an "IPPS comparable" DSH adjustment, where applicable, that is determined using the best available SSI data at the time of claim payment (See 42 CFR 412.529(d)(4)).

Updated data files

The SSI/Medicare beneficiary data for hospitals are available electronically and contain the name of the hospital, Centers for Medicare & Medicaid Services (CMS) certification number, SSI days, total Medicare days, and the ratio of days for patients entitled to Medicare Part A attributable to SSI recipients. The files are located at the following CMS website addresses:

- IPPS: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*
- IRF: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html*
- LTCH: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html*

The data is used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning and during fiscal year (FY) 2016 (cost reporting periods beginning on or after October 1, 2015, and before October 1, 2016), except when explicitly directed otherwise by CMS.

Background

Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that for discharges occurring on or after May 1, 1986, an additional payment must be made to IPPS hospitals serving a disproportionate share of low-income patients. The additional payment is determined by multiplying the federal portion of the diagnosis-related group (DRG) payment by the DSH adjustment factor, and beginning for discharges occurring on or after October 1, 2014, the additional payment is determined by multiplying the DRG payment by the DSH adjustment factor reduced by 75 percent. (See 42 CFR 412.106.)

Under the IRF PPS, IRFs will receive an additional payment amount to account for the cost of furnishing care to low-income patients. The additional payment is determined by multiplying the federal prospective payment by the low-income patient adjustment formula (See 42 CFR 412.624(e)(2)).

Additional information

The official instruction, CR 10527, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2043OTN.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
March 16, 2018	Initial article released.

MLN Matters® Number: MM10527
Related CR Release Date: March 16, 2018
Related CR Transmittal Number: R2043OTN
Related Change Request (CR) Number: 10527
Effective Date: April 16, 2018
Implementation Date: April 16, 2018

April update to the FQHC PPS for 2018 – recurring file update

Note: *This article was revised February 23, 2018, to reflect the revised change request (CR) 10480 issued February 23. The article was revised to include further information in the Background section, regarding payment methodology for federally qualified health centers (FQHCs) under the prospective payment system (PPS). This information was previously published in the February 2018 Medicare A Connection, page 22.*

Provider type affected

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

Provider action needed

Change request (CR) 10480 updates the FQHC PPS grandfathered tribal FQHC base payment rate and the geographic adjustment factors (GAFs) for the FQHC Pricer. Make sure your billing staffs are aware of these changes.

Background

Payment for FQHCs under the prospective payment system (PPS)

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111–148 and Pub. L. 111–152) added section 1834(o) of the Social Security Act to establish a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates. In the PPS for FQHC final rule published in the May 2, 2014, *Federal Register* (79 FR 25436), the Centers for Medicare & Medicaid Services (CMS) implemented a methodology and payment rates for FQHCs under the PPS beginning October 1, 2014. Note that:

- Under the FQHC PPS, Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically necessary face-to-face FQHC visit is furnished to a Medicare beneficiary.
- Beginning in 2017, the FQHC PPS rate is updated annually by the FQHC market basket. Based on historical data through second quarter 2017, the FQHC market basket for calendar year (CY) 2018 is 1.9 percent.
- From January 1, 2018 through December 31, 2018, the FQHC PPS base payment rate is $166.60. The 2018 base payment rate reflects a 1.9 percent increase above the 2017 base payment rate of $163.49.
- In accordance with Section 1834(o)(1)(A) of the Act, The FQHC PPS base rate is adjusted for each FQHC by the FQHC geographic adjustment factor (GAF), based on the geographic practice cost indices (GPCIs) used to adjust payment under the physician fee schedule (PFS). The FQHC GAF is adapted from the work and practice expense GPCIs, and are updated when the work and practice expense GPCIs are updated for the PFS.
- The Bipartisan Budget Act of 2018 revised the 2018 Work GPCI floor. Therefore, the FQHC GAFs have been updated in order to be consistent with the statutory requirements.

Payment for grandfathered tribal FQHCs that were provider-based clinics on or before April 7, 2000

Effective for dates of service on or after January 1, 2016, Indian Health Service (IHS) and tribal facilities and organizations may seek to become certified as grandfathered tribal FQHCs, if they:

1. Met the conditions of 42 CFR Section 413.65(m), which is available at *https://www.ecfr.gov/cgi-bin/text-idx?SID=19dd7fa703112dee60510c39b8c4c2ae&mc=true&node=pt42.2.413&rgn=div5#se42.2.413_165*,on or before April 7, 2000, and
2. Have
   - A change in their status on or after April 7, 2000, from IHS to tribal operation, or vice versa, or
   - The realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the Conditions of Participation (CoPs).

These grandfathered tribal FQHCs would be required to meet all FQHC certification and payment requirements. The grandfathered PPS rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS.

Grandfathered tribal FQHCs are paid the lesser of their charges or a grandfathered tribal FQHC PPS rate for all FQHC services furnished to a beneficiary during a medically-necessary, face-to-face FQHC visit. Note that:

- From January 1, 2018, through December 31, 2018, the grandfathered tribal FQHC PPS rate is $383.
- FQHC claims (TOB 77x) for grandfathered tribal FQHCs submitted with dates of service on or after January 1, 2018, through March 31, 2018, paid at the 2017 rate of $349 must be adjusted and paid at the 2018 rate of $383. These adjustments will be completed 90 days after the implementation of CR 10480.
- Grandfathered tribal FQHC claims with dates of service on or after January 1, 2019, through December 31, 2019, should be paid at the 2018 rate of $383 until the Centers for Medicare & Medicaid Services (CMS) provides an updated payment rate for 2019.

The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC GAFs or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an Initial preventive physical examination (IPPE) or an annual wellness visit (AWV). The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the FQHC market basket adjustment that

See **FQHC**, page 32

April quarterly update for 2018 DMEPOS fee schedule

Provider type affected

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

Provider action needed

Change request (CR) 10503 provides the April 2018 Medicare DMEPOS fee schedule quarterly update. It provides specific instructions to your DME MAC for implementing updated oxygen volume adjustments.

When necessary, the DMEPOS fee schedule is updated quarterly, to implement fee schedule amounts for new codes, to correct any fee schedule amounts for existing codes (as applicable) and to apply changes in payment policies. It contains fee schedule amounts for both non-rural and rural areas. Additionally, the parenteral and enteral nutrition (PEN) fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parental nutrition items.

There were no Quarter 2, 2018, rural ZIP code changes, so an April 2018 DMEPOS rural ZIP code file will not be furnished as part of this update; and there was no change to the PEN fee schedule file for Quarter 2, 2018, so a new PEN fee schedule file will not be furnished as part of this update.

Background

Section 1834(a), (h), and (i) of the Social Security Act (the Act) require payment for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings be completed on a fee schedule basis. Further, payment on a fee schedule basis is a regulatory requirement at *42 Code of Federal Regulations* (CFR) §414.102s, for parenteral and enteral nutrition, splints, casts and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, 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 amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

The methodologies for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR §414.210(g). The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjustments, as well as codes that are not subject to the fee schedule CBP adjustments.

Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in Transmittal 3551, CR 9642, dated June 23, 2016, and Transmittal 3416, CR 9431, dated November 23, 2015. You can find the *MLN Matters*® articles associated with these change requests at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf*, and *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9431.pdf*, respectively.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental metropolitan statistical areas (MSA) are not included in the DMEPOS rural ZIP code file. The DMEPOS rural ZIP code file is updated on a quarterly basis as necessary.

The fee schedules public use files (PUFs) will be available

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is applied annually to the FQHC PPS base rate will not apply to the grandfathered tribal FQHC PPS rate.

Additional information

The official instruction, CR 10480, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3982CP.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 12, 2018	Initial article released.

MLN Matters® Number: MM10480 *Revised*
Related CR Release Date: February 23, 2018
Related CR Transmittal Number: R3982CP
Related Change Request (CR) Number: 10480
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

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for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the data files on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html*.

K0903

As part of this update, CR 10503 is adding fee schedule amounts for HCPCS code K0903 (For diabetics only, multiple density insert, made by direct carving with CAM technology from a rectified CAD model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each), effective for claims with dates of service on or after April 1, 2018. The fees for code K0903 are set based on the fees for code A5513 because inserts carved from a digitized scan of the patient's foot were determined to be comparable to inserts made over a positive model of the patient's foot.

Oxygen volume adjustments

As part of the 2017 April quarterly DMEPOS fee schedule update (Please refer to the associated *MLN Matters*® article at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9988.pdf*), the 'QF' modifier (prescribed amount of oxygen is greater than four liter per minute (LPM) and portable oxygen is prescribed) was added to the DMEPOS fee schedule for use with both stationary and portable oxygen when the oxygen flow rate exceeds four liters per minute (LPM) and portable oxygen is prescribed.

- Section 1834(a)(5)(C) and (D) of the Act requires that when an oxygen flow rate exceeds four LPM, the Medicare payment amount be the higher of
- 50 percent of the stationary payment amount (HCPCS codes E0424, E0439, E1390, or E1391); or
- The portable oxygen add-on amount (HCPCS codes E0431, E0433, E0434, E1392, or K0738); and
- Never both.

The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen 'QF' fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount; or 2) The fee schedule amount for the portable oxygen add-on amount. The 'QF' modifier is billed on both the stationary oxygen and portable oxygen code when the prescribed amount of oxygen is greater than 4 LPM, portable oxygen is prescribed, **and there is no difference in the prescribed flow rate for nighttime and daytime use.**

CR 10503 provides that effective April 1, 2018:

- The 'QF' modifier is revised to read as follows:
  - QF – (PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS ; and

- The following new oxygen volume adjustment modifier is added to the HCPCS file:
  - QB – (PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED).

Specifically (effective April 1, 2018), the modifier 'QB' should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) **when the prescribed amount of oxygen for daytime and nighttime differ** and the average of the two amounts is greater than four liters per minute (LPM) and portable oxygen is prescribed. For more information April 1, 2018, changes to the pricing modifiers for oxygen flow rate, please refer to *MLN Matters*® article MM10158, titled "Revised and new modifiers for oxygen flow rate."

Please note that the 'QB' modifier is used in billing to denote when: 1) The average prescribed amount of oxygen is greater than four LPM; 2) Portable oxygen is prescribed; and 3) There is a difference in the prescribed flow rates for nighttime and for daytime use. In these instances, regulations at 42 CFR 414.226(e)(3)(iii) require that an average of the varying nighttime and daytime flow rates is to be used in determining the volume adjustment. Therefore, the 'QB' modifier is used when the average of the nighttime and daytime flow rates exceed four LPM and portable oxygen is prescribed.

In addition, please note that Section 1834(a)(5)(C) and (D) of the Act also applies to the 'QB' modifier. This section of the Act requires that, when the oxygen flow rate exceeds four LPM, the Medicare payment amount is to be: 1) The higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1391); or 2) The portable oxygen add-on amount (E0431, E0433, E0434, E1392 or K0738); and 3) Never both.

To facilitate this payment calculation, CR 10503 adds the 'QB' modifier (effective April 1, 2018) to the DMEPOS fee schedule file, for both stationary and portable oxygen.

The stationary oxygen 'QB' modifier fee schedule amounts

See **DMEPOS**, page 34

April update to the 2018 Medicare physician fee schedule database

Provider type affected

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

Provider action needed

Change request (CR) 10488 amends payment files issued to MACs based upon the calendar year 2018 Medicare physician fee schedule (MPFS) final rule. Make sure your billings staffs are aware of these changes.

Background

Payment files were issued to contractors based upon the 2018 MPFS final rule, published in the *Federal Register* November 15, 2017, to be effective for services furnished between January 1, 2018, and December 31, 2018. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

CR 10488 presents a summary of the changes for the April update to the 2018 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2018.

CPT®/HCPCS & Mod	Action
G0516	Change in short descriptor on 4-1-18 to "insert drug implant,>=4"
45399	Global days = YYY
G9976	Procedure status = I
G9977	Procedure status = I
83992	Procedure status = I

The following "Q" codes are effective for services performed on or after April 1, 2018 (see *MLN Matters*® article *MM10454* for additional information):

CPT® code	Short descriptor	Action
Q2041	Axicabtagene ciloleucel car+	Procedure status = E; there are no RVUs
Q5101	Injection, zarxio	Change in short descriptor
Q5102	Inj., infliximab biosimilar	Procedure status = I (invalid); code discontinued 4-1-18 & after
Q5103	Injection, inflectra	Procedure status = E; there are no RVUs
Q5104	Injection, renflexis	Procedure status = E; there are no RVUs

The HCPCS "G" codes listed below have been added to the MPFSDB effective for dates of service on and after April 1, 2018. All of these new codes were communicated through other instructions. Please consult those instructions for the description and other information. In addition, the descriptions are available also at *https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.html*.

CPT®/HCPCS & Mod	Action
G9873	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9874	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply

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represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen 'OB' fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount or 2) the fee schedule amount for the portable oxygen add-on amount.

Additional information

The official instruction, CR 10503, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4004CP.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
March 22, 2018	Initial article released.

MLN Matters® Number: MM10503
Related CR Release Date: March 21, 2018
Related CR Transmittal Number: R4004CP
Related Change Request (CR) Number: 10503
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

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CPT®/HCPCS & Mod	Action
G9875	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9876	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9877	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9878	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9879	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9880	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9881	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9882	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9883	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9884	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9885	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9890	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9891	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply

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

Additional information

The official instruction, CR 10488, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3976CP.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
February 16, 2018	Initial article released.

MLN Matters® Number: MM10488
Related Change Request (CR) Number: 10488
Related CR Release Date: February 16, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3976CP
Implementation Date: April 2, 2018

Submit cost report information using SPOT

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

Appropriate-use criteria for advanced diagnostic imaging – voluntary participation and reporting period - claim processing requirements – modifier QQ

Provider type affected

This *MLN Matters*® article is intended for physicians, facilities and other practitioners billing Part B services to Medicare administrative contractors (MACs) for advanced diagnostic imaging provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10481 informs the MACs of the appropriate Healthcare Common Procedure Coding System (HCPCS) modifier (QQ) that may be reported on the same claim line as the *Current Procedural Terminology* (CPT®) code for an advanced diagnostic imaging service that is furnished in an applicable setting and paid for under an applicable payment system.

Background

The Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b), established a new program to increase the rate of appropriate advanced diagnostic imaging services provided to Medicare beneficiaries. Examples of such advanced imaging services include computerized tomography, positron emission tomography, nuclear medicine, and magnetic resonance imaging. Under this program, at the time a practitioner orders an advanced imaging service for a Medicare beneficiary, he/she will be required to consult a qualified Clinical Decision Support Mechanism (CDSM). CDSMs are the electronic portals through which practitioners access appropriate use criteria (AUC) during the patient workup. The CDSM will provide the ordering professional with a determination of whether the order adheres, or does not adhere, to AUC, or if there is no AUC applicable. A list of qualified CDSMs is available at *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html*.

A consultation must take place for an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid under an applicable payment system. Please note that the applicable setting is where the imaging service is furnished, not the setting where the imaging service is ordered.

Applicable settings include physician offices, hospital outpatient departments (including emergency departments), ambulatory surgical centers, and any other provider-led outpatient setting determined appropriate by the Secretary of Health and Human Services (at this time, no other settings have been identified). Applicable payment systems include the physician fee schedule (PFS), the hospital outpatient prospective payment system (OPPS), and the ambulatory surgical center payment system.

When this program is more fully implemented (expected January 1, 2020), consultation with a qualified CDSM will be required and detailed information regarding the ordering professional's consultation must be appended to the furnishing professional's claim. This includes the ordering practitioner's national provider identifier (NPI) and documenting which CDSM was consulted (there are multiple qualified CDSMs available). The Centers for Medicare and Medical Services (CMS) does not have guidance at this time regarding what the claim-based reporting requirements will be in 2020. In addition, this program will include exceptions to consulting CDSMs that include:

1. The ordering professional having a significant hardship,
2. Situations in which the patient has an emergency medical condition, or,
3. An applicable imaging service ordered for an inpatient, and for which payment is made under Part A.

Ultimately, this program will result in identified outlier ordering professionals being subject to prior authorization.

Regulatory language for this program is in *42 Code of Federal Regulation* 414.94 titled *Appropriate Use Criteria for Advanced Diagnostic Imaging Services*. In the calendar year 2018 PFS final rule, CMS stated that the program would begin with a voluntary participation period. During this period, ordering professionals may choose to consult qualified CDSMs; and furnishing professionals may choose to report limited consultation information on their Medicare claims.

Effective July 1, 2018, HCPCS modifier QQ (ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional) is available for this reporting. The modifier may be:

- Used when the furnishing professional is aware of the result of the ordering professional's consultation with a CDSM for that patient,
- Reported on the same claim line as the CPT® code for an advanced diagnostic imaging service furnished in an applicable setting and paid for under an applicable payment system, and,
- Reported on both the facility and professional claim.

You should be aware that, effective for claims with dates of service on or after July 1, 2018, your MACs will accept the new QQ modifier on the same claim line as any CPT® codes that fall within the ranges shown below.

Please note that the QQ modifier may also appear on the same claim line as a CPT® code that falls outside the range; and, until further notice, MACs will continue to pay claims for services within, or outside, the CPT® code range shown below regardless of the presence of the QQ modifier.

See **QQ**, page 37

QQ

from page 36

Magnetic resonance imaging

70336, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 71550, 71551, 71552, 71555, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72195, 72196, 72197, 72198, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74181, 74182, 74183, 74185, 75557, 75559, 75561, 75563, 75565, 76498

Computerized tomography

70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71275, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72191, 72192, 72193, 72194, 73200, 73201, 73202, 73206, 73700, 73701, 73702, 73706, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74261, 74262, 74712, 74713, 75571, 75572, 75573, 75574, 75635, 76380, 76497,

Single-photon emission computed tomography

76390

Nuclear medicine

78012, 78013, 78014, 78015, 78016, 78018, 78020, 78070, 78071, 78072, 78075, 78099, 78102, 78103, 78104, 78110, 78111, 78120, 78121, 78122, 78130, 78135, 78140, 78185, 78191, 78195, 78199, 78201, 78202, 78205, 78206, 78215, 78216, 78226, 78227, 78230, 78231, 78232, 78258, 78261, 78262, 78264, 78265, 78266, 78267, 78268, 78270, 78271, 78272, 78278, 78282, 78290, 78291, 78299, 78300, 78305, 78306, 78315, 78320, 78350, 78351, 78399, 78414, 78428, 78445, 78451, 78452, 78453, 78454, 78456, 78457, 78458, 78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78491, 78492, 78494, 78496, 78499, 78579, 78580, 78582, 78597, 78598, 78599, 78600, 78601, 78605, 78606, 78607, 78608, 78609, 78610, 78630, 78635, 78645, 78647, 78650, 78660, 78699, 78700, 78701, 78707, 78708, 78709, 78710, 78725, 78730, 78740, 78761, 78799, 78800, 78801, 78802, 78803, 78804, 78805, 78806, 78807, 78811, 78812, 78813, 78814, 78816, 78999

Additional information

The official instruction, CR 10481, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2040OTN.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
March 2, 2018	Initial article released.

MLN Matters® Number: MM10481
Related CR Release Date: March 2, 2018
Related CR Transmittal Number: R2040OTN
Related Change Request (CR) Number: 10481
Effective Date: July 1, 2018
Implementation Date: July 2, 2018

Medicare Learning Network®

The *Medicare Learning Network*® (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

ICD-10 and other coding revisions to NCDs

Note: Editorial corrections made May 23, 2018, to correct link to transmittal number.

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

Change request (CR) 10473 constitutes a maintenance update of the International Classification 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/CR10473.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 10473 makes coding and clarifying adjustments to the following NCDs:

1. NCD20.5 Extracorporeal Immunoadsorption (ECI) Using Protein A Columns
2. NCD110.18 Aprepitant
3. NCD110.21 Erythropoiesis Stimulating Agents (ESAs)
4. NCD150.3 Bone Mineral Density Studies
5. NCD190.1 Histocompatibility Testing
6. NCD190.11 PT/INR
7. NCD210.3 Colorectal Cancer Screening
8. NCD210.4.1 Counseling to Prevent Tobacco Use
9. NCD210.6 Hepatitis B Virus Screening
10. NCD220.4 Mammograms
11. NCD220.6.17 PET for Solid Tumors
12. NCD250.4 Actinic Keratosis (AKs)

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

- 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 10473, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2039OTN.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
March 1, 2018	This article was revised to reflect an updated CR. That CR corrected instructions in business requirement 7 (NCD210.3), including the spreadsheet for MACs. The CR release date, transmittal number and link to the transmittal also changed.
February 21, 2018	Initial article released.

MLN Matters® Number: MM10473
Related Change Request (CR) Number: 10473
Related CR Release Date: February 28, 2018
Effective Date: July 1, 2018
Related CR Transmittal Number: R2039OTN
Implementation Date: April 2, 2018, for local MAC edits; July 2, 2018, for shared system edits

April 2018 update of drug and biological code changes

***Note**: This article was revised March 8 to reflect an updated CR. That CR provides additional instructions for the MACs, regarding use of the long descriptors. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged. This information was previously published in the February 2018 Medicare A Connection, page 23.*

Provider type affected

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

What you need to know

The HCPCS code set is updated on a quarterly basis. Change request (CR) 10454 informs MACs of the April 2018 updates of specific biosimilar biological product HCPCS code, modifiers used with these biosimilar biologic products and an autologous cellular immunotherapy treatment. Be sure your staffs are aware of these updates.

Background

CR 10454 describes updates associated with the following biosimilar biological product HCPCS codes and modifiers. The April 2018 HCPCS file includes three new HCPCS codes: Q5103, Q5104, and Q2041 Also, the April 2018 HCPCS file includes a revision to the descriptor for HCPCS code Q5101.

Effective for services as of April 1, 2018, The April 2018 HCPCS file includes these revised/new HCPCS codes:

- HCPCS code: Q5101
  - Short description: Injection, zarxio
  - Long description: Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram
- HCPCS code: Q5103
  - Short description: Injection, inflectra
  - Long description: Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg
  - Type of service (TOS) code: 1,P
  - Medicare physician fee schedule database (MPFSDB) status indicator: E
- HCPCS code: Q5104
  - Short description: Injection, renflexis
  - Long description: Injection, infliximab-abda, biosimilar, (renflexis), 10 mg
  - TOS code: 1, P
  - MPFSDB status indicator: E
- HCPCS code:Q2041
  - Short description: Axicabtagene ciloleucel car+
  - Long description: Axicabtagene Ciloleucel, up to 200 million autologous Anti-CD19 CAR T Cells, Including leukapheresis and dose preparation procedures, per infusion
  - TOS code: 1
  - MPFSDB status indicator: E

Effective for claims with dates of service on or after April 1, 2018, HCPCS code Q5102 (which describes both currently available versions of infliximab biosimilars) will be replaced with two codes, Q5103 and Q5104. Thus, Q5102 Injection, infliximab, biosimilar, 10 mg, will be discontinued, effective March 31, 2018.

Also, beginning on April 1, 2018, modifiers that describe the manufacturer of a biosimilar product (for example, ZA, ZB and ZC) will no longer be required on Medicare claims for HCPCS codes for biosimilars. However, please note that HCPCS code Q5102 and the requirement to use biosimilar modifiers remain in effect for dates of service prior to April 1, 2018.

Medicare Part B policy changes for biosimilar biological products were discussed in the 2018 physician fee schedule (PFS) final rule at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html*. Effective January 1, 2018, newly approved biosimilar biological products with a common reference product will no longer be grouped into the same billing code. The rule also stated that instructions for new codes for biosimilars that are currently grouped into a common payment code and the use of modifiers would be issued.

Additional information

The official instruction, CR 10454, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3997CP.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
March 8, 2018	This article was revised to reflect an updated CR. That CR provided additional instructions for the MACs, regarding use of the long descriptors. The CR date, transmittal number and link to the transmittal also changed. All other information is unchanged.
February 2, 2018	Initial article released.

MLN Matters® Number: MM10454 *Revised*
Related CR Release Date: March 7, 2018
Related CR Transmittal Number: R3997CP
Related Change Request (CR) Number: 10454
Effective Date: April 1, 2018
Implementation Date: April 2, 2018

Quarterly update for clinical laboratory fee schedule and services subject to reasonable charge payment

***Note**: This article was revised March 15 to reflect an updated change request (CR). That CR removed the list of new codes with a QW modifier that were effective as of April 1, 2018, from the policy section. All other information remains the same. This information was previously published in the February 2018 Medicare A Connection, pages 26-27.* ***Note: Editorial corrections made May 23, 2018, to correct related CR release date and transmittal number**.*

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.

Provider action needed

Change request (CR) 10445 which informs the MACs about the changes in the April 2018 quarterly update to the clinical laboratory fee schedule (CLFS). Make sure that your billing staffs are aware of these changes.

Background

Effective January 1, 2018, CLFS rates will be based on weighted median private payor rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, visit PAMA Regulations, at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*. Part B deductible and coinsurance do not apply for services paid under the CLFS.

Access to data file

Internet access to the quarterly CLFS data file will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the Internet to retrieve the quarterly clinical laboratory fee schedule. The file will be available in multiple formats: Excel, text, and comma delimited.

Pricing information

The CLFS includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Social Security Act.

New codes

The following new codes will be MAC priced, until they are addressed at the annual Clinical Laboratory Public Meeting, which will take place in July, 2018. The following "U" codes shall have HCPCS pricing indicator code - 22 = Price established by A/B MACs Part B (e.G., gap-fills, A/B MACs Part B established panels) instead of pricing indicator - 21 = Price subject to national limitation amount. (code, long descriptor, short descriptor, effective date, type of service (TOS))

0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative GLYCA NUC MR SPECTRSC QUAN 1/1/2018 5

0025U Tenofovir, by liquid chromatography with tandem mass spectrometry (LC-MS/MS), urine, quantitative TENOFOVIR LIQ CHROM UR QUAN 1/1/2018 5

0026U Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy") ONC THYR DNA&MRNA 112 GENES 1/1/18 5

0027U JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15 JAK2 GENE TRGT SEQ ALYS 1/1/18 5

0028U CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis CYP2D6 GENE CPY NMR CMN VRNT 1/1/18 5

0029U Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823) RX METAB ADVRS TRGT SEQ ALYS 1/1/18 5

0030U Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823) RX METAB WARF TRGT SEQ ALYS 1/1/18 5

0031U CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(eg, drug metabolism) gene analysis, common variants (ie, *1F, *1K, *6, *7) CYP1A2 GENE 1/1/18 5

0032U COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant COMT GENE 1/1/18 5

0033U HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (eg, citalopram metabolism) gene analysis, common variants (ie, HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.-759C>T] and rs1414334 [c.551-3008C>G]) HTR2A HTR2C GENES 1/1/18 5

0034U TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(eg, thiopurine metabolism), gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5) TPMT NUDT15 GENES 1/1/18 5

The following new code is effective January 1, 2018:

New code 87634QW is priced at the same rate as 87634.

See **CLFS**, page 41

Supervised exercise therapy for symptomatic peripheral artery disease

***Note**: The article was revised March 5, 2018, to reflect a revised change request (CR). The MAC implementation date, CR release date, transmittal numbers and the web addresses of the transmittals were revised. All other information remains the same. Editorial errors have also been corrected in the "Document history" and CR details at the end of the article. This information was previously published in the February 2018 Medicare A Connection, pages 24-25.*

Provider type affected

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

Provider action needed

Change request (CR) 10295 informs MACs that effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) to cover supervised exercise therapy (SET) for beneficiaries with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD). Make sure your billing staffs are aware of these changes.

Background

SET involves the use of intermittent walking exercise, which alternates periods of walking to moderate-to-maximum claudication, with rest. SET has been recommended as the initial treatment for patients suffering from IC, the most common symptom experienced by people with PAD.

Despite years of high-quality research illustrating the effectiveness of SET, more invasive treatment options (such as, endovascular revascularization) have continued to increase. This has been partly attributed to patients having limited access to SET programs. There is currently no NCD in effect.

CMS issued the NCD to cover SET for beneficiaries with IC for the treatment of symptomatic PAD. Up to 36 sessions over a 12-week period are covered if all of the following components of a SET program are met:

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Be conducted in a hospital outpatient setting, or a physician's office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Be under the direct supervision of a physician (as defined in Section 1861(r)(1)) of the Social Security Act (the Act), physician assistant, or nurse practitioner/

See **PAD**, page 42

CLFS

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Deleted codes

The following codes are deleted effective January 1, 2018:

Existing code 0004U is to be deleted.
Existing code 0015U is to be deleted.
Existing code 81280 is to be deleted.
Existing code 81281 is to be deleted.
Existing code 81282 is to be deleted.

Code update

Existing code 80410 had an incorrect crosswalk (multiplier of 1 instead of 3) in the annual CLFS file, and is corrected with this CR in the quarterly file, effective January 1, 2018.

Additional information

The official instruction, CR 10445, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3999CP.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
March 15, 2018	The article was revised to reflect an updated CR. That CR removed the list of new codes with a QW modifier that were effective as of April 1, 2018, from the policy section.
February 9, 2018	Initial article released.

MLN Matters® Number: MM10445
Related CR Release Date: March 14, 2018
Related CR Transmittal Number: R3999CP
Related Change Request (CR) Number: 10445
Effective Date: January 1, 2018, for new HCPCS codes, otherwise April 1, 2018
Implementation Date: April 2, 2018

PAD

from page 41

clinical nurse specialist (as identified in Section 1861(aa)(5) of the Act)) who must be trained in both basic and advanced life support techniques.

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

MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions over an extended period of time. MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the services that documentation is on file verifying that further treatment beyond the 36 sessions of SET over a 12-week period meets the requirements of the medical policy. SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary attending physician.

Coding requirements for SET

Providers should use *Current Procedural Terminology* (CPT®) 93668 (under peripheral arterial disease rehabilitation) to bill for these services with appropriate International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) code as follows:

- I70.211 – right leg
- I70.212 – left leg
- I70.213 – bilateral legs
- I70.218 – other extremity
- I70.311 – right leg
- I70.312 – left leg
- I70.313 – bilateral legs
- I70.318 – other extremity
- I70.611 – right leg
- I70.612 – left leg
- I70.613 – bilateral legs
- I70.618 – other extremity
- I70.711 – right leg
- I70.712 – left leg
- I70.713 – bilateral legs
- I70.718 – other extremity

Medicare will deny claim line items for SET services when they do not contain one of the above ICD-10 codes using the following messages:

- Claim adjustment reason code (CARC) 167 – This (these) diagnosis (es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remark code (RARC) N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

MACs will accept claims for CPT® 93668 only when services are provided in Place of Service (POS) code 11, 19, or 22. MACs will deny claims for SET if services are not provided in POS 11, 19, or 22, using the following remittance messages:

- CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note**: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- RARC N386: This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Institutional claims for SET must be submitted on type of bills (TOB) 13x or 85x. MACs will deny line items on institutional claims that are not submitted on TOB 13x or 85x using the following messages:

- CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **Note**: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- RARC N386: “This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

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Medicare will pay claims for SET services containing CPT® code 93668 on types of bill (TOBs) 13x under OPPS and 85x on reasonable cost, except it will pay claims for SET services containing CPT® 93668 with revenue codes 096x, 097x, or 098x when billed on TOB 85x method II critical access hospitals (CAHs) based on 115 permission of the lesser of the fee schedule amount or the submitted charge.

Medicare will reject claims with CPT® 93668 which exceed 36 sessions within 84 days from the date of the first session when the KX modifier is not included on the claim line OR any SET session provided after 84 days from the date of the first session and the KX modifier is not included on the claim and use the following messages:

- CARC 96: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N640: Exceeds number/frequency approved/ allowed within time period.
- 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.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

MACs will deny/reject claim lines for SET exceeding 73 sessions using the following codes:

- CARC 119: Benefit maximum for this time period or occurrence has been reached.
- RARC N386: "This decision was based on a National Coverage Determination 20.35 (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (contractual obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
- Group code PR (patient responsibility) assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

Medicare's common working file (CWF) will display remaining SET sessions on all CWF provider query screens (HIQA, HIQH, ELGH, ELGA, and HUQA). The multi-carrier system desktop tool will also display remaining SET sessions in a format equivalent to the CWF HIMR screen(s).

Additional information

The official instruction, CR 10295, was issued to your MAC via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3992CP.pdf*. The second updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R205NCD.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
March 5, 2018	The article was revised to reflect a revised CR. The MAC implementation date, CR release date, transmittal numbers and the Web addresses of the transmittals were revised. All other information remains the same.
February 6, 2018	Initial article released.

MLN Matters® Number: MM10295
Related CR Release Date: March 2, 2018
Related CR Transmittal Number: R205NCD and R3992CP
Related Change Request (CR) Number: 10295
Effective Date: May 25, 2017
Implementation Date: April 2, 2018 – MAC edits; July 2, 2018 – full implementation

Upcoming provider outreach and educational events

Topic: Medicare Part A changes and regulations

Date: Tuesday, June 12
Time: 10:00-11:30 a.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0402688.asp

Topic: Ask-the-contractor teleconference (ACT): Medicare provider enrollment process (A/B)

Date: Wednesday, June 13
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast

https://medicare.fcso.com/Events/0402681.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 February 22, 2018

MLN Connects® for February 22, 2018
View this edition as a PDF

News & Announcements

- Low Volume Appeals Settlement Process

Provider Compliance

- Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities — Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Update Call — March 13
- Open Payments: The Program and Your Role Call — March 14
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20
- CMS National Provider Enrollment Conference — April 24 and 25

Medicare Learning Network Publications & Multimedia

- CMS Provider Minute Video: Utilizing Your MAC to Prepare for CERT Review — New
- Low Volume Appeals Settlement Call: Audio Recording and Transcript — New
- Provider Compliance Tips for Hospital Beds and Accessories Fact Sheet — New
- Provider Compliance Tips for Infusion Pumps and Related Drugs Fact Sheet — New
- Provider Compliance Tips for Nebulizers and Related Drugs Fact Sheet — New
- Provider Compliance Tips for Laboratory Tests – Blood Counts Fact Sheet — New
- Provider Compliance Tips for Diabetic Test Strips Fact Sheet — Revised
- Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model MLN Matters Article — Revised
- Telehealth Services Booklet — Revised
- Medicare Enrollment for Institutional Providers Booklet — Revised
- PECOS for Physicians and NPPs Booklet — Revised
- DMEPOS Information for Pharmacies Fact Sheet — Reminder
- DMEPOS Accreditation Fact Sheet — Reminder
- Mass Immunizers and Roster Billing Booklet — Reminder

Medicare Learning Network®

The *Medicare Learning Network*® (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

Medicare expired legislative provisions extended and other Bipartisan Budget Act of 2018 provisions

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018. This new law includes several provisions related to Medicare payment.

With regard to payment for outpatient therapy services, the law repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record; and retains the targeted medical review process, but at a lower threshold amount. It also extends several recently expired Medicare legislative provisions affecting health care providers and beneficiaries, including the Medicare physician fee schedule work geographic adjustment floor, add-on payments for ambulance services and home health rural services, changes to the payment adjustment for low volume hospitals, and the Medicare dependent hospital program.

In addition, with regard to Section 53111 – Medicare Payment Update for Skilled Nursing Facilities, the Centers for Medicare & Medicaid Services has received questions from stakeholders about the impact of the FY 2019 skilled nursing facility (SNF) update due to Section 53111 of the

BBA of 2018. To help answer these questions, we are providing information about the estimated market-basket update for FY 2019 based on currently available data. This estimate may be updated in the notice of proposed rulemaking for the FY 2019 SNF prospective payment system (PPS).

Read the *full summary*.

MLN Connects® for March 1, 2018

MLN Connects® for March 1, 2018
View this edition as a PDF

News & Announcements

- New Medicare Card: Video for Your Waiting Room
- Patients over Paperwork Newsletter
- CMS Launches Public Reporting of CAHPS® Hospice Survey Results
- Hospice Compare Quarterly Refresh
- Medicare Diabetes Prevention Program: Supplier Enrollment
- Medicare EHR Incentive Program Hospital Attestation: Deadline Extended to March 16
- Draft 2019 QRDA Category I Implementation Guide: Submit Comments by March 21
- MIPS: Apply to Participate in Quality Measures Study by March 23
- MIPS Reporting Deadlines
- MIPS 2018 QCDR Measure Specifications
- MIPS Claims Based Quality Measures Projections and Results Video
- eCQM Annual Update Pre-Publication Document
- What's New with Physician Compare Webinar Materials
- Are You Prepared for a Health Care Emergency?
- March is National Colorectal Cancer Awareness Month

Provider Compliance

- Provider Compliance Tips for Laboratory Blood Counts Fact Sheet – New

Upcoming Events

- Low Volume Appeals Settlement Option Update Call – March 13
- Open Payments: The Program and Your Role Call – March 14
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call – March 20
- E/M Services: Documentation Guidelines and Burden Reduction Listening Session – March 21

Medicare Learning Network Publications & Multimedia

- Provider Compliance Tips for PAP Devices and Accessories Including CPAP Fact Sheet – New
- Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction Fact Sheet – New
- Provider Compliance Tips for Bariatric Surgery Fact Sheet – New
- Provider Compliance Tips for Diabetic Shoes Fact Sheet – New

See **Connects®**, page 47

MLN Connects® for March 8, 2018

MLN Connects® for March 8, 2018

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News & Announcements

- MyHealthEData Initiative Puts Patients at the Center of the US Health Care System
- New Medicare Card Transition Begins In Less Than a Month
- MACRA Funding Opportunity: Measure Development for the Quality Payment Program
- IRF and LTCH Compare Refresh
- Quality Payment Program: Submit 2017 Participation Data through March 31
- EHR Incentive Program: Hospitals Submit Proposals for New Measures until June 29
- PEPPER for Short-term Acute Care Hospitals
- DME Supplier Feedback on Telephone Discussion and Reopening Process Demonstration
- EHR Incentive Programs FAQs
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Help Your Patients Go Further With Food

Provider Compliance

- Bill Correctly for Device Replacement Procedures – Reminder

Claims, Pricers & Codes

- April 2018 Average Sales Price Files

Upcoming Events

- Low Volume Appeals Settlement Option Update Call – March 13
- National Patient Safety Week Panel Discussion – March 13
- Open Payments: The Program and Your Role Call – March 14
- QRDA Category I Implementation Guide for CY 2018 Hospital Quality Reporting Webinar – March 19
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call – March 20
- E/M Services: Documentation Guidelines and Burden Reduction Listening Session – March 21

Medicare Learning Network Publications & Multimedia

- Provider Compliance Tips for Glucose Monitors Fact Sheet – New
- Provider Compliance Tips for Manual Wheelchairs Fact Sheet – New
- Provider Compliance Tips for Ordering Lower Limb Prostheses Fact Sheet – New
- Provider Compliance Tips for Laboratory Tests – Bacterial Cultures Fact Sheet – New
- Provider Compliance Tips for Wheelchair Options/ Accessories Fact Sheet – New
- Provider Compliance Tips for Ostomy Supplies Fact Sheet – New
- Provider Compliance Tips for Ordering Oxygen Supplies and Equipment Fact Sheet – New
- Provider Compliance Tips for Negative Pressure Wound Therapy Fact Sheet – New
- Provider Compliance Tips for Surgical Dressings Fact Sheet – New
- Provider Compliance Tips for Urological Supplies Fact Sheet – New
- Low Volume Appeals Settlement Call: Video Presentation – New
- ESRD QIP Call: Audio Recording and Transcript – New
- Rural Health Clinic Fact Sheet — Revised

CONNECTS®

from page 46

- Provider Compliance Tips for Lower Limb Orthoses Fact Sheet – New
- Provider Compliance Tips for Enteral Nutrition Fact Sheet – New
- Provider Compliance Tips for Immunosuppressive Drugs Fact Sheet – New
- Provider Compliance Tips for Ambulance Services Fact Sheet – Revised
- Provider Compliance Tips for Clinic ESRD Services (Part A Non-DRG) Fact Sheet – Revised
- Provider Compliance Tips for CT Scans Fact Sheet – Revised
- Medicare Part D Vaccines and Vaccine Administration Fact Sheet – Revised
- Medicare Part B Immunization Billing Educational Tool – Revised
- Screening Pap Tests and Pelvic Examinations Booklet – Revised
- Medicare Enrollment for Physicians, NPPs, and Other Part B Suppliers Booklet – Revised
- Hospital Outpatient Prospective Payment System Booklet – Revised

MLN Connects® for March 15, 2018

MLN Connects® for March 15, 2018
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News & Announcements

- MIPS Reporting Deadlines Approaching
- EHR Incentive Program: Hospital Attestation Deadline Changed to March 16
- Hospice Provider Preview Reports: Review Your Data by March 30
- IRF and LTCH Provider Preview Reports: Review Your Data by April 5
- Medicare Pharmaceutical and Technology Ombudsman
- Updated QRDA III Implementation Guide with Advancing Care Information Identifier
- Hospice QRP Timeliness Compliance Threshold Report: Footnote Update
- Influenza Activity Continues: Are Your Patients Protected?

Provider Compliance

- Provider Compliance Tips for Hospital Beds and Accessories

Claims, Pricers & Codes

- Integrated OCE Files for April 2018

Upcoming Events

- New Medicare Card Project Special Open Door Forum — March 20
- Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20
- E/M Services: Documentation Guidelines and Burden Reduction Listening Session — March 21
- Interdisciplinary Team Building, Management, and Communication Webinar — March 21
- Hospice Quality Reporting Program Webinar — March 27
- IMPACT Act and Improving Care Coordination Special Open Door Forum — March 28
- Managing Transitions with Adults with Disabilities Webinar — March 28
- Building Partnerships: Health Plans and Community-based Organizations Webinar — April 4

Medicare Learning Network Publications & Multimedia

- Appropriate Use Criteria for Advanced Diagnostic Imaging: HCPCS Modifier QQ MLN Matters Article — New
- April 2018 I/OCE Specifications Version 19.1 MLN Matters Article — New
- April 2018 Update of the Hospital OPPS MLN Matters Article — New
- Provider Compliance Tips for Enteral Nutrition Fact Sheet — New
- Provider Compliance Tips for Walkers Fact Sheet — New
- Provider Compliance Tips for Home Health Services Fact Sheet — New
- Provider Compliance Tips for Respiratory Assistive Devices Fact Sheet— New
- ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised
- Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients MLN Matters Article — Revised
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Quarterly HCPCS Drug/Biological Code Changes MLN Matters Article — Revised
- Provider Compliance Tips for Laboratory Tests: Other Fact Sheet – Revised
- Provider Compliance Tips for Ordering Hospital Outpatient Services Fact Sheet — Revised
- Provider Compliance Tips for Skilled Nursing Facility Services Fact Sheet — Revised
- Provider Compliance Tips for Enteral Nutrition Therapy Pumps Fact Sheet — Revised
- Provider Compliance Tips for IRF Fact Sheet — Revised
- Ambulatory Surgical Center Payment System Fact Sheet — Revised
- Beneficiaries in Custody under a Penal Authority Fact Sheet—Revised
- Medicare Ambulance Transports Booklet — Revised
- Medicare Provider-Supplier Enrollment National Educational Products Listing — Revised
- Global Surgery Booklet — Reminder

MLN Connects® for March 22, 2018

MLN Connects® for March 22, 2018

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News & Announcements

- Coverage of Next Generation Sequencing Tests Ensures Enhanced Access for Cancer Patients
- IMPACT Act Transfer of Health Measures: Public Comment Period Ends May 3
- Hospice Quality Reporting Program: HART v1.4.0
- Hospital VBP Program FY 2020 Baseline Measures Report

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Upcoming Events

- IMPACT Act and Improving Care Coordination Special Open Door Forum — March 28
- Spinal Orthoses Referring Providers Comparative Billing Report Webinar — April 11
- CMS National Provider Enrollment Conference — April 24 and 25

Medicare Learning Network Publications & Multimedia

- April 2018 Update: ASC Payment System MLN Matters® Article — New
- Internet Only Manual Update to Correct Errors and Omissions: SNF 2018 MLN Matters® Article — New
- SSI/Medicare Beneficiary Data for FY 2016: IPPS Hospitals, IRFs, LTCHs MLN Matters® Article — New
- Billing Requirements for OPPS Providers with Multiple Service Locations MLN Matters® Article — New

- Reinstating the QMB Indicator in the Medicare FFS Claims Processing System MLN Matters® Article — Revised
- Quarterly Update for CLFS and Laboratory Services Subject to Reasonable Charge Payment MLN Matters® Article — Revised
- Home Health Prospective Payment System Booklet — Revised
- Federally Qualified Health Center Booklet — Revised
- Medicare Parts A and B Appeals Process Booklet — Reminder
- The Medicare Secondary Payer Provisions Web-Based Training Course — Reminder
- CLIA Program and Medicare Laboratory Services — Reminder

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