Medicare A CONNECTION
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
April 2018

In this issue

Increased ambulance payment reduction for non-emergency basic life support transports to and from dialysis facilities

Provider type affected

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

Provider action needed

Change request (CR) 10549 provides instructions regarding Section 53108 of the Bipartisan Budget Act of 2018. This section reduces the ambulance payment by 23 percent for non-emergency basic life support (BLS) transports of individuals with end-stage renal disease (ESRD), to and from renal dialysis treatment (at both hospital-based and free-standing renal dialysis treatment facilities). Please make sure your billing staffs are aware of these changes.

Background

Payment for ambulance transports (including items and services furnished in association with such transports) are based on the ambulance fee schedule (AFS) and include a base rate payment plus a separate payment for mileage. This raised payment reduction for non-emergency BLS transports to and from renal dialysis treatment applies to both the base rate and the mileage reimbursement.

CR 8269, issued May 10, 2013, implemented Section 637 of the American Taxpayer Relief Act of 2012, which, for transports occurring on and after October 1, 2013; required a 10 percent reduction in fee schedule payments for non-emergency (BLS transports of beneficiaries with ESRD); to and from both hospital-based and freestanding renal dialysis treatment facilities, for non-emergent dialysis services. The *MLN Matters*® article associated with this CR is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8269.pdf*.

CR 10549 provides instructions regarding Section 53108 of the Bipartisan Budget Act of 2018, (signed into law February 9, 2018), which requires that, effective October 1, 2018, the reduction of fee schedule payments for

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Contents

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

Processing Issues

Outpatient claims: Correcting deductible and coinsurance for code G0473

Issue

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

HCPCS code = G0473

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

Types of bill = 13x

Resolution

The IOCE update has been implemented; Medicare administrative contractors will initiate mass adjustment of these claims no later than March 3.

Status/date resolved

Closed; all mass adjustments have been completed.

Provider action

There is no action required by the provider.

Current processing issues

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

General Information

Medicare fee-for-service response to the 2017 California wildfires

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries, who were affected by the 2017 wildfires in the state of California.

Provider information available

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of the 2017 wildfires, a major disaster exists in the state of California.

On October 15, 2017, Acting Secretary Hargan of the Department of Health & Human Services declared that a public health emergency exists in the state of California retroactive to October 8, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On October 17, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the state of California retroactive to October 8, 2017, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 waiver by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Note: The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired January 5, 2018.

Background

Section 1135 and Section 1812(f) waivers

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

Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of California retroactive to October 8, 2017, for the duration of the emergency. In accordance with CR 6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

The most current information can be found at *https://www.cms.gov/About-CMS/Agency- Information/Emergency/Wildfires.html*.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the state of California. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable **without** any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency.
- Another file addresses policies and procedures that are applicable **only with** approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved individual 1135 waivers requested by providers for California.

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

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

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Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf.

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

Waiver for California

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following waiver in the affected areas of California. Individual facilities do not need to apply for the following approved waiver.

Skilled nursing facilities

- 1812(f): This waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility stay provides temporary emergency coverage of skilled nursing facility (SNF) services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).
- In addition, the waiver provides temporary emergency coverage of SNF services that are not post-hospital SNF services under the authority in §1812(f) of the Social Security Act (the Act), for those people who are evacuated, transferred, or otherwise dislocated as a result of the effects in the state of California, in October 2017. In addition, this waiver provides authority under §1812(f) of the Act to provide coverage for extended care services which will not require a new spell of illness in order to renew provision of services by a SNF. These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under §1135 of the Act in connection with the effects of the wildfires in the state of California in October 2017. Accordingly, both the effective date and expiration date for these temporary emergency policies are the same as those specified pursuant to the §1135 waivers. Further, unlike the policies authorized directly under the §1135 waiver authority itself, the two policies described above would not be limited to beneficiaries who have been relocated within areas that have been designated as emergency areas. Instead, the policies would apply to all beneficiaries who were evacuated from an emergency area as a result of the effects of the wildfires in California in October 2017, regardless of where the "host" SNF providing post-disaster care is located.

Administrative relief

Appeal administrative relief for areas affected by California wildfires

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

Requesting an 1135 waiver

Information for requesting an 1135 waiver can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

More information is available in the 1135 waiver letter, which is posted in the *Downloads* section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html*.

Medicare quality reporting and value-based purchasing programs

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to acute care hospitals, inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, long-term care hospitals, renal dialysis facilities, and ambulatory surgical centers located in areas affected by the devastating impacts of the northern California wildfires since October 8, 2017, in and around counties in northern California. For complete details of these exceptions, see the document posted at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Memo-Requirements-Facilities-CA-Wildfires.pdf*.

Additional information

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

Document history

Date of change	Description
April 2, 2018	The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired January 5, 2018.
November 1, 2017	This article was revised to add information regarding the exceptions granted for certain Medicare quality reporting and value-based purchasing programs.
October 18, 2017	Initial article released.

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Medicare fee-for-service response to the 2017 Southern California wildfires

***Note**: This article was revised April 2, 2018, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired March 3, 2018. All other information remains the same. This information was previously published in the December 2017 Medicare A Connection, pages 23-24.*

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries, who were affected by the December 2017 wildfires in the state of California.

Provider information available

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of the December 2017 Wildfires, an emergency exists in the state of California.

On December 11, 2017, Acting Secretary Hargan of the Department of Health & Human Services declared that a public health emergency (PHE) exists in the state of California retroactive to December 4, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On December 13, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the state of California retroactive to December 4, 2017, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 waiver by following the instructions available at *https://www.cms.gov/About-CMS/Agency- Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Note: The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired March 3, 2018.

Background

Section 1135 and Section 1812(f) Waivers

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

Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of California retroactive to December 4, 2017, for the duration of the emergency. In accordance with CR 6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

The most current information is available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html*.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the state of California. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable **without** any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency.
- Another file addresses policies and procedures that are applicable **only with** approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved individual 1135 waivers requested by providers for California.

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

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MLN Matters® Number: SE17035
Related CR Release Date: April 2, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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

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

Waiver for California

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

Skilled nursing facilities

- 1812(f): This waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).
- In addition, the waiver provides temporary emergency coverage of SNF services that are not post-hospital SNF services under the authority in §1812(f) of the Social Security Act (the Act), for those people who are evacuated, transferred, or otherwise dislocated as a result of the effects in the state of California, in December 2017. In addition, this waiver provides authority under §1812(f) of the Act to provide coverage for extended care services which will not require a new spell of illness in order to renew provision of services by a SNF. These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under §1135 of the Act in connection with the effects of the wildfires in the state of California in December 2017. Accordingly, both the effective date and expiration date for these temporary emergency policies are the same as those specified pursuant to the §1135 waivers. Further, unlike the policies authorized directly under the §1135 waiver authority itself, the two policies described above would not be limited to beneficiaries who have been relocated within areas that have been designated as emergency areas. Instead, the policies would apply to all beneficiaries who were evacuated from an emergency area as a result of the effects of the wildfires in California in December 2017, regardless of where the "host" SNF providing post-disaster care is located.

Administrative relief

Appeal administrative relief for areas affected by California wildfires

If you were affected by the California wildfires and are unable to file a timely appeal, respond to pending requests for documentation, or experience an interruption in the receipt of the remittance advice (RA) that lists the initial determination(s), please contact your MAC.

Requesting an 1135 Waiver

Information for requesting an 1135 waiver is available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

More information is available in the 1135 Waiver letter, which is posted in the *Downloads* section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html*.

Additional information

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

Document history

Date of change	Description
April 2, 2018	The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired March 3, 2018.
December 18, 2017	Initial article released.

MLN Matters® Number: SE17037 *Revised*
Article Revised Date: April 2, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: 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.

Retired LCD

Topical photosensitizers used with PDT for actinic keratoses and certain skin cancers – retired Part A and Part B LCD

LCD ID number: L33414 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for topical photosensitizers used with PDT for actinic keratoses and certain skin cancers, it was determined that this LCD is no longer required. Therefore, the LCD and the associated coding guidelines are being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after April 10, 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*.

Revisions to LCD

Biofeedback – revision to the Part A and Part B LCD

LCD ID number: L33615 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for biofeedback has been updated to revise language in the "Limitations of Coverage" section of the LCD.

Effective date

The LCD revision is effective for claims processed **on or after April 3, 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*.

Intravenous immune globulin – revision to the Part A and Part B LCD

LCD ID number: L34007 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the intravenous immune globulin 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 a quotation from a Centers for Medicare & Medicaid Services (CMS) source. Therefore, this LCD has been revised to remove the italics from the language.

Effective date

This LCD revision is effective for services rendered **on or after April 12, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

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

Based on an external correspondence, the local coverage determination (LCD) for magnetic resonance angiography (MRA) was revised in the "CPT®/HCPCS Codes" section of the LCD to remove language referring to hospital outpatient prospective payment system (OPPS) and ambulatory surgical centers (ASCs). All the "C" procedure codes listed in the LCD are billable to hospital OPPS and ASCs. Therefore, the "CPT®/HCPCS Codes" section of the LCD was revised to consolidate the Part A and Part B groups that support medical necessity and groups that do not support medical necessity.

Effective date

This LCD revision is effective for claims processed **on or after April 12, 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*.

Vertebroplasty, vertebral augmentation; percutaneous – revision to the Part A and Part B LCD

LCD ID number: L34976 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an external correspondence, the vertebroplasty, vertebral augmentation; percutaneous local coverage determination (LCD) was revised in the "CPT®/HCPCS Codes" section of the LCD to remove *Current Procedural Terminology* (CPT®) code 76380. The remaining procedure codes listed in the LCD are inclusive of all imaging guidance.

In addition, based on an annual review of the LCD, it was determined that the language in the "Coverage Indications, Limitations, 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 manual language.

Effective date

The LCD revision to remove CPT® code 76380 is effective for claims processed **on or after April 17, 2018.** The LCD revision to assure consistency with manual language is effective for services rendered **on or after April 17, 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*.

Additional Information

Noncovered services – revision to the Part A and Part B coding guidelines article (A54675)

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

The noncovered services local coverage determination (LCD) "coding guidelines" article is revised to remove deleted *Current Procedural Terminology* (CPT®) code 35452 from the "Procedures for Part B" section of the coding guidelines.

Effective date

The LCD revision is effective for claims processed **on or after April 12, 2018,** for services rendered **on or after January 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*.

Manual update regarding ambulance transportation for a SNF resident in a stay not covered by Part A

Provider type affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNF), ambulance providers and suppliers providing ambulance services to patients and billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries who are not in a covered Part A stay.

Provider action needed

Change request (CR) 10550 provides clarification on coverage of an ambulance transport for a SNF resident in a stay not covered by Part A, who has Part B benefits, to the nearest supplier of medically necessary services not available at the SNF, including the return trip. These clarifications relate to Chapter 10 of the *Medicare Benefit Policy Manual*, and Chapter 15, of the *Medicare Claims Processing Manual*. The revised manual sections are attachments to CR 10550. Make sure your billing staffs are aware of these clarifications.

Background

In the June 17, 1997, ambulance proposed rule (62 FR 32720), the Centers for Medicare & Medicaid Services (CMS) proposed a provision under Part B that permits ambulance transportation from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is an inpatient, including the return trip. CMS finalized this proposal in the January 25, 1999, final rule (64 FR 3648) at 42 CFR 410.40(e)(3).

CMS is revising the *Medicare Benefit Policy Manual* and *Medicare Claims Processing Manual* to clarify that a medically necessary ambulance transport from an SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident (including the return trip) may be covered under Part B. This applies to beneficiaries who are in an SNF stay not covered by Part A, but who has Part B benefits.

For example, this includes ambulance transport of such residents from the SNF (modifier N) to the nearest diagnostic or therapeutic site, other than a physician's office or hospital, such as an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, or wound care center, as reported with ambulance modifier D. For SNF residents receiving Part A benefits, this type of ambulance service is subject to SNF consolidated billing.

Additional information

The official instruction, CR 10550, issued to your MAC regarding this change, consists of two transmittals. The first updated the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4021CP.pdf*. The second transmittal updates the *Medicare Benefit Policy Manual* and it is at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R243BP.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
April 13, 2018	Initial article released.

MLN Matters® Number: MM10550
Related CR Release Date: April 13, 2018
Related CR Transmittal Number: R243BP and R4021CP
Related Change Request (CR) Number: 10550
Effective Date: July 16, 2018
Implementation Date: July 16, 2018

SNF advance beneficiary notice of non-coverage

Provider type affected

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

Provider action needed

This article informs you about change request (CR) 10567, which advises you that the Centers for Medicare & Medicaid Services (CMS) has revised the skilled nursing facility notice of non-coverage (SNF ABN), Form CMS-10055. With this revision, CMS is discontinuing the five SNF denial letters (namely, the Intermediary Determination of Noncoverage, the UR Committee Determination of Admission, the UR Committee Determination on Continued Stay, the SNF Determination on Admission and the SNF Determination on Continued Stay), and the Notice of Exclusion from Medicare Benefits (NEMB-SNF), Form CMS-20014. Please ensure that your billing staffs are aware of these changes.

Please note that the Notice of Medicare Non-Coverage (NOMNC), Form CMS-10123 is not being discontinued with this revised SNF ABN. More information on the NOMNC is available at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.html*.

See **ABN**, page 11

SNF value-based purchasing program updated

Provider type affected

This *MLN Matters*® article is intended for physicians, clinical staff, and administrators of skilled nursing facilities (SNFs) submitting claims under the SNF prospective payment system (PPS) to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries during an SNF stay.

Provider action needed

Special edition article SE18003 informs providers about the SNF value-based purchasing (VBP) program. The VBP Program is one of many VBP programs that aim to reward quality and improve health care. Beginning October 1, 2018, SNFs will have an opportunity to receive incentive payments based on their performance in the program.

Background

On August 4, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1679-F) outlining fiscal year (FY) 2018 Medicare payment rates for SNFs. This final rule finalized SNF VBP Program scoring and operational policies, including an exchange function approach to implement incentive payment adjustments beginning October 1, 2018.

Scoring and operational updates

The SNF VBP program's scoring and operational policies affecting payment determination in FY 2019 include:

- The adjusted Federal per diem rate applicable to each SNF in an FY will be reduced by two percent to fund incentive payments for that FY.

See **VBP**, page 12

ABN

from page 10

Background

The authorization for these requirements are Section 1879 of the Social Security Act and 42 Code of Federal Regulations (CFR) 411.404(b) and (c), which specify written notice requirements. These requirements are fulfilled by the SNF ABN.

In order for SNFs to transfer liability to an original Medicare beneficiary for items or services paid under Medicare Part A (SNF prospective payment system (PPS)), the SNF must issue a

SNF ABN for:

- An item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary, or
- Custodial care.

Attached to CR 10567 is a revised Chapter 30 of the *Medicare Claims Processing Manual*. This revised manual chapter provides details on SNF ABN standards and also provides information about:

- Situations in which a SNF ABN should be given
- Situations in which a SNF ABN Is not needed to transfer financial liability to the beneficiary
- SNF ABN specific delivery issues
- Special rules for SNF ABNs
- Establishing when beneficiary is on Notice of Non-coverage

Note: Further details are available at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN-.html*. You may download the revised Form CMS-10055 in the *Downloads* section of that web page.

SNFs will continue to use the advance beneficiary notice of non-coverage (ABN, Form CMS-R-131) for items or services that Medicare may be deny under Medicare Part B.

Please note that SNFs may start to implement this new notice any time up to the implementation date of CR 10567. Upon the CR 10567 implementation April 30, 2018, the use of the new notice is mandatory.

The revised notice incorporates suggestions for changes made by users of the ABN and by beneficiary advocates based on experience with the current form, refinements made to similar liability notices through consumer testing and other means, as well as related Medicare policy changes and clarifications.

Additional information

The official instruction, CR 10567, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4011CP.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 30, 2018	Initial article released.

MLN Matters® Number: MM10567
Related CR Release Date: March 30, 2018
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Related Change Request (CR) Number: 10567
Effective Date: April 30, 2018
Implementation Date: April 30, 2018

VBP

from page 11

- The total amount of incentive payments distributed to SNFs will be 60 percent of the total amount withheld from SNFs' Medicare payments for that FY. Facilities with SNF VBP performance scores ranked in the lowest 40 percent nationally will receive a payment rate lower than they would otherwise receive without the SNF VBP Program.
- SNF 30-day all-cause readmission measure (SNFRM) rates from the baseline year (calendar year 2015) affecting FY 2019 payment determinations are now publicly available on the nursing home compare and SNF VBP Program websites.

Payment exchange function

CMS finalized a logistic exchange function to translate SNF performance scores into value-based incentive payments beginning in the FY 2019 SNF VBP program. The logistic function maximizes the number of SNF with positive payment adjustment at a 60-percent payback percentage, while balancing Medicare's long-term sustainability. For more information about the logistic exchange function, refer to the FY 2018 SNF PPS final rule at *https://www.gpo.gov/fdsys/pkg/FR-2017-08-04/pdf/2017-16256.pdf*.

Review and corrections process

CMS clarified the review and corrections process for SNFs' performance data that will be made publicly available on nursing home compare. During the annual review and corrections 30-day period, the review scope is limited to correction requests regarding SNFs' performance score and ranking information.

FY 2020 performance and baseline periods

CMS adopted FY 2018 as the performance period and FY 2016 as the baseline period for the FY 2020 SNF VBP program. The transition from measuring SNFs' performance during a CY period to a Federal FY period allows for a 12-month performance period and baseline period for both program years.

Table 1 provides details on the performance periods and baseline periods for the FY 2019 and FY 2020 program years.

Table 1: Performance and baseline periods for FY 2019 & 2020 program years

Period	FY 2019 program year	FY 2020 program year
Performance period	CY 2017 (Jan. 1-Dec. 31, 2017)	FY 2018 (Oct. 1, 2017-Sept. 30, 2018)
Baseline period	CY 2015 (Jan. 1-Dec. 31, 2015)	FY 2016 (Oct. 1, 2015-Sept. 30, 2016)

Public reporting

CMS will rank SNFs for the FY 2019 program year and publish the rankings after the review and corrections process has completed. The published file will include, but may not be limited to, the following data elements to provide consumers and other stakeholders the necessary information to evaluate SNFs' performance in the program:

- Rank
- Provider ID
- Facility name
- Address
- Each SNF's baseline period (CY 2015) and performance period (CY 2017) Risk Standardized Readmission Rate (RSRR)
- National average baseline period (CY 2015) and performance period (CY 2017) RSRR
- Achievement score
- Improvement score
- Performance score
- The range of performance scores
- The number of SNFs receiving value-based payments
- The range and total amount of value-based payments

Additional information

For more information about the SNF VBP program, go to *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html* and refer to FY 2018 SNF PPS final rule at *https://www.gpo.gov/fdsys/pkg/FR-2017-08-04/pdf/2017-16256.pdf*.

If you have additional questions, please email them to: *SNFVBPinquiries@cms.hhs.gov*.

You may also direct questions to 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 28, 2018	Initial article released.

MLN Matters® Number: SE18003
Related CR Release Date: March 28, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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

***Note**: This article was revised April 4, 2018, to reflect a revised change request (CR) issued April 3. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same. This information was previously published in the March 2018 Medicare A Connection, page 23.*

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

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/R2050OTN.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
April 3, 2018	The article was revised to reflect a revised CR. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.
	Initial article released.

MLN Matters® Number: MM10397 *Revised*
Related CR Release Date: April 3, 2018
Related CR Transmittal Number: R2050OTN
Related Change Request (CR) Number: 10397
Effective Date: July 1, 2018
Implementation Date: July 2, 2018

Clarification of institutional billing for no cost items

Provider type affected

This *MLN Matters*® article is intended for Institutions (Part A) billing Medicare administrative contractors (MACs) for no cost items provided to Medicare beneficiaries.

What you need to know

Change request (CR) 10521 provides clarification of the billing instructions specific to drugs provided at no cost when claims processing edits prevent drug administration charges from being billed when the claim does not contain a covered/billable drug charge. This is not a new policy but a reminder of the policy in place. Please make sure your billing staffs are aware of this clarification.

Background

The *Medicare Claims Processing Manual* Chapter 32 - *Billing Requirements for Special Services* section 67.2 outlines institutional billing for no cost items as follows.

Institutional providers should not have to report the usage of a no cost item. However, for some claims (for example, outpatient prospective payment system (OPPS) claims), providers may be required to bill a no cost item due to claims processing edits that require an item (even if received at no cost) to be billed along with an associated service (for example, a specified device must be reported along with a specified implantation procedure).

For OPPS claims, when a drug is provided at no cost, claim processing edits prevent drug administration charges from being billed when the claim does not contain a covered/billable drug charge. Therefore, for drugs provided at no cost in the hospital outpatient department, providers must report the applicable drug HCPCS code and appropriate units with a token charge of less than $1.01 for the item in the covered charge field and mirror this less than $1.01 amount reported in the non-covered charge field. Providers must also bill the corresponding drug administration charge with the appropriate drug administration CPT® or HCPCS code.

Additional information

The official instruction, CR 10521, issued to your

MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4013CP.pdf*.

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

Document history

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MLN Matters® Number: MM10521
Related CR Release Date: March 30, 2018
Related CR Transmittal Number: R4013CP
Related Change Request (CR) Number: 10521
Effective Date: January 1, 2009
Implementation Date: June 29, 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*.

ADJUSTMENT

from page 1

BLS transports to and from renal dialysis treatments be increased to 23 percent.

Non-emergency BLS ground transports are identified by Healthcare Common Procedure Coding System (HCPCS) code A0428 (Ambulance service, basic life support, non-emergency transport, (BLS)). Ambulance transports to and from renal dialysis treatment are further identified by origin/destination modifier codes "G" (hospital-based ESRD) and "J" (freestanding ESRD facility), in either the origin or destination position of an ambulance modifier.

Specific details

- Effective for claims with dates of service on and after October 1, 2018, payment for non-emergency BLS transports to and from renal dialysis treatment facilities will be reduced by 23 percent. The reduced rate will be calculated after the normal payment rate (including any applicable add-on payments) is calculated, and will be applied to the base rate for non-emergency BLS transports (identified by HCPCS code A0428 when billed with the indicated modifier codes) and the associated, separate mileage payment (identified by HCPCS code A0425).
- Payment for emergency transports and non-emergency BLS transports to other destinations (rural and urban) will remain unchanged. The AFS will also remain unchanged.
- For ambulance services, suppliers and hospital-based ambulance providers must report an accurate origin and destination modifier for each ambulance trip provided. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates a modifier. The first position alpha code equals origin; the second position alpha code equals destination.
- The reduction will be applied on claim lines containing HCPCS code A0428 with modifier code "G" or "J", in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier code and HCPCS code A0425.
- MACs will keep in place all existing edits and logic (implemented previously via CMS CR 8269) that currently apply to the reduced AFS payment rates; however, effective for claims with dates of service on or after October 1, 2018, will increase the reduction from 10 percent to 23 percent. Additionally, they will continue to use the claim adjustment reason code, group code and Medicare summary notice messages that are currently used for the reduced AFS payment methodology

Note: This 23-percent reduction applies to beneficiaries with ESRD that are receiving a non-emergency BLS transport to and from renal dialysis treatment. While it is possible that a beneficiary who is not diagnosed with ESRD will require routine transport to and from renal dialysis treatment, it is highly unlikely. However, MACs have the discretion to override or reverse the reduction on appeal if they deem it appropriate based on supporting documentation.

Additional information

The official instruction, CR 10549, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4017CP.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
April 6, 2018	Initial article released.

MLN Matters® Number: MM10549
Related CR Release Date: April 6, 2018
Related CR Transmittal Number: R4017CP
Related Change Request (CR) Number: 10549
Effective Date: October 1, 2018
Implementation Date: October 1, 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*.

Proper coding for specimen validity testing billed in combination with drug testing

Provider type affected

This *MLN Matters*® article is intended for laboratories and other providers billing Medicare administrative contractors (MACs) for urine drug test services provided to Medicare beneficiaries.

Provider action needed

This *MLN Matters*® special edition article reminds laboratories and other providers about how to properly bill for specimen validity testing done in conjunction with drug testing. This article contains no policy changes, but serves as a reminder to laboratories and providers of current Medicare requirements. Please make sure your billing staffs are aware of these instructions.

Background

The Centers for Medicare & Medicaid Services (CMS) is issuing SE18001 to remind laboratories and other providers about the correct coding and instructions for billing specimen validity testing when done as a part of drug testing.

Section 1862(a)(1)(A) of the Social Security Act provides that Medicare payment may not be made for services that are not reasonable and necessary. Clinical laboratory services must be ordered and used by the physician who is treating the beneficiary as described in 42 CFR 410.32(a), or by a qualified nonphysician practitioner, as described in 42 CFR 4310.32(a)(3).

Current coding for testing for drugs of abuse relies on a structure of "screening" (known as "presumptive" testing) and "quantitative" or "definitive" testing that identifies the specific drug and quantity in the patient.

Beginning January 1, 2017, presumptive drug testing may be reported with CPT® codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

The descriptors for presumptive drug testing codes are:

- **80305**: Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
- **80306**: Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) read by instrument-assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
- **80307**: Drug tests(s), presumptive, any number of drug classes, qualitative, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service.

As mentioned in the *National Correct Coding Initiative Policy Manual*, Chapter 10, Section E, beginning January 1, 2016, definitive drug testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.

The descriptors for definitive drug testing codes are:

- **G0480**: Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed
- **G0481**: Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed

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SPECIMEN

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- **G0482**: Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed
- **G0483**: Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed

In addition, definitive drug testing code G0659 was created to recognize those laboratories that are performing a less sophisticated version of these tests than is usually performed in drug testing laboratories:

- **G0659**: Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes

The work performed in this test approximates the work performed in CPT® code 80307.

Providers performing validity testing on urine specimens utilized for drug testing *shall* not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.

Additional information

The *National Correct Coding Initiative Policy Manual* is available in the *Downloads* section of *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

The Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) recently completed a report that illustrated improper payments for specimen validity tests as part of urine drug testing. To review that report, visit *https://oig.hhs.gov/oas/reports/region9/91602034.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 29, 2018	Initial article released.

MLN Matters® Number: SE18001
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Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

July 2018 update of drug and biological code changes

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) 10624 informs MACs of updated drug/biological HCPCS codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes four new HCPCS codes: Q9991, Q9992, Q9993 and Q9995. Please make sure your billing staffs are aware of these updates.

Background

The July 2018 HCPCS file includes four new HCPCS codes, which are payable by Medicare, effective for claims with dates of service on or after July 1, 2018. These codes are:

- **Q9991**
  - Short description: Buprenorph xr 100 mg or less
  - Long description: Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
  - Type of service (TOS) code: 1
  - Medicare physician fee schedule database (MPFSDB) status indicator: E
- **Q9992**
  - Short description: Buprenorphine xr over 100 mg
  - Long description: Injection, buprenorphine extended-release (sublocade), greater than 100 mg
  - TOS code: 1
  - MPFSDB status indicator: E
- **Q9993**
  - Short description: Inj., triamcinolone ext rel
  - Long description: Injection, triamcinolone acetonide, preservative-free, extended release, microsphere formulation, 1 mg
  - TOS code: 1,P
  - MPFSDB status indicator: E
- **Q9995**
  - Short description: Inj. emicizumab-kxwh, 0.5 mg
  - Long description: Injection, emicizumab-kxwh, 0.5 mg
  - TOS code: 1
  - MPFSDB status indicator: E

Additional information

The official instruction, CR 10624, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4025CP.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
April 20, 2018	Initial article released.

MLN Matters® Number: MM10624
Related CR Release Date: April 20, 2018
Related CR Transmittal Number: R4025CP
Related Change Request (CR) Number: 10624
Effective Date: July 1, 2018
Implementation Date: July 2, 2018

Alcohol misuse screening and counseling

About 38 million adults in the United States drink too much. Only one in six adults have talked to a health professional. Alcohol screening and brief counseling has been proven to work and talking to your patient is the first step!

All Medicare beneficiaries are eligible for alcohol screening. Medicare beneficiaries who screen positive are eligible for counseling if both of the following are met:

- Competent and alert at the time counseling is provided.
- Counseling is furnished by qualified primary care physician or other primary care practitioners in a primary care setting.

Learn more about this positive preventive benefit on the *Centers for Medicare & Medicaid Services (CMS) MLN Educational Tool, Medicare Preventive Services*.

Supervised exercise therapy for symptomatic peripheral artery disease

***Note**: The article was revised April 5, 2018, to reflect a revised change request (CR). The Medicare administrative contractor (MAC) implementation date, CR release date, transmittal numbers, and the web addresses of the transmittals were revised. In addition, the article and CR were revised to delete place of service (POS) codes 19 and 22 as acceptable POS for CPT® 93668. The article was also revised April 11, 2018, to clarify that the supervised exercise therapy (SET) program must be provided in a physician's office (POS 11). All other information remains the same. March 2018 Medicare A Connection, pages 41-43.*
Note: Editorial corrections made May 23, 2018, to second bullet and transmittal numbers/links.

Provider type affected

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

Provider action needed

CR 10295 informs MACs that effective May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) to cover 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 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/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:

See **PAD**, page 20

PAD

from page 19

- 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 POS code 11. MACs will deny claims for SET if services are not provided in POS 11 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.

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 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).

See **PAD**, page 21

PAD

from page 20

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/R4016CP.pdf*. The second updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R206NCD.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
April 11, 2018	The article was revised to clarify that the SET program must be provided in a physician's office (POS code 11). All other information remains the same.
April 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. In addition, the article and CR were revised to delete POS codes 19 and 22 as acceptable places of service for CPT® 93668. All other information remains the same.

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 *Revised*
Related CR Release Date: April 3, 2018
Related CR Transmittal Number: R206NCD and R4016CP
Related Change Request (CR) Number: 10295
Effective Date: May 25, 2017
Implementation Date: July 2, 2018

Find out first: Subscribe to First Coast *eNews*

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Claim processing actions to implement certain provisions of the Bipartisan Budget Act of 2018

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) 10531 provides direction to MACs to reprocess claims related to several provisions of the Bipartisan Budget Act of 2018, referred to as Medicare extenders. Specifically, the CR provides guidance to MACs regarding Medicare fee-for-service (FFS) claim reprocessing requirements and timeframes. Make sure your billing staffs are aware of these changes.

Background

On February 9, 2018, Congress passed the Bipartisan Budget Act of 2018 which contains a number of provisions that extend certain Medicare FFS policies, including ambulance add-on payment provisions, the work geographic practice cost index (GPCI) floor, and the three percent home health (HH) rural add-on payment. In addition, the Act permanently repeals the outpatient therapy caps beginning January 1, 2018, while retaining the requirement to submit the KX modifier for services in excess of the prior cap amounts. Due to the retroactive effective dates of these provisions, your MAC will reprocess various Medicare FFS claims impacted by this legislation.

Section 421(a) of the Medicare Modernization Act (MMA), as amended by Section 50208 of the Social Security Act, provides an increase of three percent of the payment amount otherwise made under Section 1895 of the Social Security Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2019. The statute waives budget neutrality related to this provision.

As a result of the work GPCI floor changes, certain federally qualified health center (FQHC) geographic adjustment factors (GAFs) will change, which may result in a change to some FQHC payments. For inpatient prospective payment system (IPPS) hospitals, temporary changes to the low-volume hospital payment adjustment and the Medicare-dependent hospital (MDH) program have been extended. In addition, for the long-term care hospital prospective payment (LTCH PPS), the blended payment rate for site neutral payment rate cases is extended for certain LTCH hospital discharges. Separate instructions addressing these payment updates are forthcoming.

On January 25, 2018, the Centers for Medicare & Medicaid Services (CMS) instructed MACs to release for processing held therapy claims with the KX modifier with dates of receipt January 1- 10, 2018. CMS also instructed the MACs to institute a “rolling hold” for all new therapy claims with the KX modifier. On February 12, 2018, CMS provided direction regarding new Medicare physician fee schedule (MPFS) files and abstract files due to the extension of the work GPCI floor, as well as a revised 2018 ambulance fee schedule (AFS) file. CMS also instructed the MACs to ensure legislative effective indicators were set correctly in Medicare systems to apply therapy policies. Given that legislation has been enacted, CMS is instructing the MACs to reprocess effected claims that were processed using the previous MPFS files.

As stipulated in Section 421(a) of the MMA, the three percent rural add-on is applied to the national, standardized episode rate, national per-visit payment rates, low-utilization payment adjustment (LUPA) add-on payments, and the non-routine supplies (NRS) conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2019. Refer to Tables 1 through 4 of the attachment to CR 10531 for the 2018 rural payment rates. CR 10531 is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2047OTN.pdf*.

Section 1848(e)(1)(E) of the Social Security Act stipulates that after calculating the work geographic index for purposes of MPFS payment for services furnished, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00. This provision expired on December 31, 2017, and the locality-specific anesthesia conversion factors for 2018 were calculated without this work geographic index floor of 1.00 in place.

Section 50201 of the Bipartisan Budget Act of 2018 restored the work geographic index floor of 1.00 and retroactively dated this restoration to January 1, 2018. In accordance with the law, CMS has updated the locality-specific anesthesia conversion factors for 2018 to include the work geographic index floor of 1.00. These updated locality-specific anesthesia conversion factors also have a retroactive effective date of January 1, 2018.

CR 10531 reminds the MACs to be aware that Section 1848(b)(4) of the Social Security Act limits MPFS payment for the technical portion of most imaging procedures to the amount paid under the outpatient prospective payment system (OPPS) system. This policy applies to the technical component (and technical portion of global payment) of imaging services, including X-ray, ultrasound, nuclear medicine, MRI, CT, and fluoroscopy services. The MPFS payment rates for some of these services does not reflect the most recent updates to the OPPS rates that were updated in December of 2017. CMS corrected these rates in new MPFS files and informed the MACs of the corrections February 12, 2018. These MPFS files also contain the updates for the GPCI. This correction is unrelated to the passage of this Act, but CMS is taking the opportunity to address this issue now since new MPFS files are required as a result of the Act.

See **BBA**, page 23

BBA

from page 22

The instructions to the MACs to reprocess claims contain the following specifics:

- The MACs will reprocess therapy claims with the KX modifier containing dates of service in 2018, which were denied prior to the implementation of the updated legislative effective dates issued January 25, 2018. **Note**: For institutional claims, these claims will include revenue codes 042x, 043x, or 044x and modifiers GN, GO, or GP.
- The MACs will reprocess therapy claims with the KX modifier which were denied due to an invalid date provided by CMS February 12, 2018.
- The MACs will reprocess 2018 therapy claims which cannot be automatically reprocessed only if you bring such claims to the attention of your MAC.
- The MACs reprocess MPFS claims for localities and states impacted by the work GPCI floor fee increase for dates of service in 2018. Please refer to the chart in Attachment A - Localities and states impacted by the work GPCI floor – 2018 – in CR 10531.
- The MACs will reprocess 2018 MPFS claims for localities and states impacted by the work GPCI floor fee increase for dates of service in 2018 which cannot be automatically reprocessed only if you bring such claims to your MAC's attention. Please refer to the chart in Attachment A - Localities and states impacted by the work GPCI floor – 2018.
- The MACs will reprocess ground AFS claims using the revised 2018 AFS file for dates of service in 2018.
- The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC's attention.
- MACs will reprocess home health claims with the following criteria:
  - Type of bill 32x
  - Claim "Through" dates on or after January 1, 2018
  - Value code 61 amounts in the range 999xx
  - Receipt dates prior to the installation of the revised home health Pricer, which reflects the extension of the 3 percent rural add-on for 2018.
- MACs will automatically reprocess claims impacted by the OPPS cap for dates of service in 2018. The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC's attention.
- The MACs will automatically reprocess anesthesia claims for localities and states impacted by the work GPCI floor fee increase for dates of service in 2018. Please refer to the chart in Attachment A - Localities and states Impacted by the work GPCI floor – 2018. The MACs will reprocess claims which cannot be automatically reprocessed only if you bring such claims to your MAC's attention.
- MACs shall ensure all reprocessing actions have been initiated within six months of the issuance of CR 10531:
  - For therapy and MPFS adjustments
  - For ground ambulance service claims with a date of service on or after 1/1/2018
  - For OPPS adjustments
  - For anesthesia adjustments
- MACs shall ensure all reprocessing actions have been initiated within six months of the implementation date of the Pricer for HH rural add-on adjustments.

Additional information

The official instruction, CR 10531, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2051OTN.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
April 5, 2018	The article was revised to reflect a revised CR 10531, which was revised to include page two of Attachment B - Rural Add on Rate Tables. In the article, the CR release date, transmittal number, and the web address for CR 10531 are revised. All other information remains the same.
April 6, 2018	Initial article released.

MLN Matters® Number: MM10531 *Revised*
Related CR Release Date: April 4, 2018
Related CR Transmittal Number: R2051OTN
Related Change Request (CR) Number: 10531
Effective Date: January 1, 2018
Implementation Date: April 2, 2018; date to begin reprocessing claims

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 March 29, 2018

MLN Connects® for March 29, 2018

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News & Announcements

- Patients Over Paperwork: Empowering Patients Through Data
- MIPS Data Submission Deadline: March 31
- Transitions from Hospice Care, Followed by Death or Acute Care Draft Measure: Comment Period Ends April 25
- Open Payments Review and Dispute Period: April 1 through May 15
- Qualified Medicare Beneficiary Claims: Replacement RAs
- MACRA Patient Relationship Categories and Codes
- Advanced Diagnostic Laboratory Tests: Applications and Guidance
- HIMSS18 Presentations
- Hospice Quality Reporting Program Video Series: Navigating HQRP Websites
- Hospice Item Set Coding Video Series
- Physician Compare Quality Measure TEP Summary Report
- Administrative Simplification: Reaching Compliance with ASETT Video

Provider Compliance

- Provider Compliance Tips for Diabetic Test Strips

Upcoming Events

- Comparative Billing Report on Spinal Orthoses Suppliers Webinar – May 2
- LTCH Quality Reporting Program In-Person Training Event – May 8 and 9
- IRF Quality Reporting Program In-Person Training Event – May 9 and 10

Medicare Learning Network Publications & Multimedia

- Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018 MLN Matters Article – New
- Adjustments to QMB Claims Processed under CR 9911 MLN Matters Article – New
- April Quarterly Update for 2018 DMEPOS Fee Schedule MLN Matters Article – New
- Low Volume Appeals Settlement Call: Audio Recording and Transcript – New
- Open Payments Call: Audio Recording and Transcript – New
- E/M Services Listening Session: Audio Recording and Transcript – New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article – Revised
- April 2018 I/OCE Specifications Version 19.1 MLN Matters Article – Revised
- April 2018 Update of the Hospital OPPS MLN Matters Article – Revised

MLN Connects® for April 5, 2018

MLN Connects® for April 5, 2018
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News & Announcements

- New Medicare Card Project – Important Updates
- Bipartisan Budget Act: CMS Reprocessing Impacted Claims
- Reducing Provider Burden: Send us Your Feedback
- MIPS Group Web Interface and CAHPS Survey: Register by June 30
- MIPS APM: Resources for Performance Year 2018
- Medicare Diabetes Prevention Program: New Resources
- Administrative Simplification: Electronic Transactions
- Opioids: CDC Online Training Series
- Opioid Overdoses Treated in Emergency Departments: CDC Vital Signs Report
- Help Prevent Alcohol Misuse or Abuse
- Reduce the Risk of Falls in Elderly Patients

Provider Compliance

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

Claims, Pricers & Codes

- HCPCS Code Set Modifications

Upcoming Events

- Cultural Competence: Meeting LTSS Needs of Beneficiaries Webinar — April 12
- Safe and Effective Use of Medications in Older Adults Webinar — April 18
- Managing Older Adults with Substance Use Disorders Webinar — May 16

Medicare Learning Network Publications & Multimedia

- Institutional Billing for No Cost Items MLN Matters Article — New
- Proper Coding for Specimen Validity Testing Billed in Combination with Drug Testing MLN Matters Article — New
- SNF ABN MLN Matters Article — New
- SNF Value-Based Purchasing Program Updated MLN Matters Article — New
- Dementia Care Call: Audio Recording and Transcript — New
- Medicare FFS Response to the 2017 California Wildfires MLN Matters Article — Updated
- Medicare FFS Response to the 2017 Southern California Wildfires MLN Matters Article — Updated
- Inpatient Psychiatric Facility PPS Booklet — Revised
- Medicare Enrollment for Providers Who Solely Order, Certify, or Prescribe Booklet — Revised
- 2018 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — Revised
- Medicare Parts A & B Appeals Process Booklet — Reminder
- Looking for Educational Materials?

MLN Connects® for April 12, 2018

MLN Connects® for April 12, 2018

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News & Announcements

- Help Your Medicare Patients Avoid and Report Scams
- 2018 MIPS Eligibility Tool
- Draft 2019 QRDA Category I Schematron: Submit Comments by April 20
- Home Health Utilization and Payment Data
- National Health Care Decisions Day is April 16

Provider Compliance

- Provider Compliance Tips for Oral Anticancer Drugs and Antiemetic Drugs Used in Conjunction

Upcoming Events

- Opioids Forum: Strategies and Solutions for Minority Communities — April 25
- Medicare Cost Report e-Filing System Webcast — May 1

Medicare Learning Network Publications & Multimedia

- Increased Ambulance Payment Reduction for Non-Emergency BLS Transports to and from Renal Dialysis Facilities MLN Matters Article — New
- New Waived Tests MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Modifications to the Implementation of the PWK Segment of the esMD System MLN Matters Article – Revised
- Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018 MLN Matters Article — Revised
- Revised and New Modifiers for Oxygen Flow Rate MLN Matters Article — Revised
- April 2018 MLN Catalog – Revised
- Medicare Home Health Benefit Booklet — Revised

MLN Connects® for April 19, 2018

MLN Connects® for April 19, 2018

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News & Announcements

- New Medicare Card: New Numbers Are Confidential
- Market Saturation and Utilization Data Tool
- MIPS Study on Burdens Associated with Reporting Quality Measures: Apply by April 30
- IMPACT Act Transfer of Health Measures: Public Comment Period Ends May 3
- PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
- National Minority Health Month: Partnering for Health Equity

Provider Compliance

- Ophthalmology Services: Questionable Billing and Improper Payments

Claims, Pricers & Codes

- April 2018 OPPS Pricer File

Upcoming Events

- Medicare Cost Report e-Filing System Webcast — May 1
- LTCH Quality Reporting Program In-Person Training Event — May 8 and 9
- IRF Quality Reporting Program In-Person Training Event — May 9 and 10

Medicare Learning Network Publications & Multimedia

- Quarterly Update to the NCCI PTP Edits, Version 24.2 MLN Matters Article — New

- Change in Type of Service for CPT Code 77067 MLN Matters Article — New
- Ambulance Transportation for SNF Resident in Stay Not Covered by Part A MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Guidelines for Teaching Physicians, Interns, and Residents Booklet — Revised
- Billing Information for Rural Providers and Suppliers Booklet — Revised
- ICD-10-CM/PCS: The Next Generation of Coding Booklet — Reminder
- General Equivalence Mappings FAQs Booklet — Reminder
- Critical Access Hospital Booklet — Reminder
- Learn About Medicare Policy

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.

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