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

In this issue

New physician specialty code for medical genetics and genomics

Provider type affected

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

Provider action needed

This article is based on change request (CR) 10457 which informs MACs that CMS has established a new physician specialty code for medical genetics and genomics (D3). Make sure that your billing staffs are aware of these changes.

Background

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or Internet-based provider enrollment, chain and ownership system (PECOS) when they enroll in the Medicare program. Medicare physician specialty codes describe the specific/unique types of medicine that physicians (and certain other suppliers) practice. The Centers for Medicare & Medicaid Services (CMS) uses specialty codes for programmatic and claim processing purposes. CMS has established a new physician specialty code for medical genetics and genomics. The new code is D3. MACs will accept and recognize the new code of D3.

Additional information

CR 10457 revises *The Medicare Financial Management Manual*, Chapter 6, and the *Medicare Claims Processing Manual*, Chapter 26, to reflect this new specialty code. The revised manual sections are attached to CR 10457.

The official instruction, CR 10457, issued to your MAC regarding this change via two transmittals. The first updates the *Medicare Financial Management Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R304FM.pdf*. The second updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4039CP.pdf*.

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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.

Medicare cost report e-filing (MCReF)

Provider type affected

This *MLN Matters*® article is intended for cost report staff submitting annual Medicare cost reports (MCRs) to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10611 informs MACs and providers of the new MCR e-filing (MCReF) system available for electronic transmission of cost reports. Medicare Part A providers file an annual MCR with the Centers for Medicare & Medicaid Services (CMS). The reports are filed with a MAC assigned to each provider. The MCR is used to determine the providers' Medicare reimbursable costs. MACs may suspend payments to providers that fail to file their MCR on the due date. Make sure your cost report staffs are aware of the new MCReF system.

Background

In accordance with *Chapter 1, Section 104 of the Provider Reimbursement Manual, Part II* (PRM-II), providers that continue to participate in the Medicare program are required to submit a cost report within five months of their cost reporting fiscal year end. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period. Exceptions to this due date for "no Medicare utilization" cost reports are addressed in PRM-II, Section 110.A. MACs are required to suspend payments to providers that fail to file their MCR by the due date.

Current Medicare cost-report (MCR) filing and receipt process: Generally, each provider must perform the following steps to properly submit an MCR to their MAC:

- Generate an MCR consisting of a machine-readable file (ECR) and a human-readable file (PDF or equivalent, also referred to as the print image), using CMS-approved MCR vendor software.
- Submit the worksheet S (certification page) signed by an officer or administrator of the provider. A "wet" signature is required for cost reports ending before December 31, 2017; an electronic signature is allowed for cost reports ending on or after December 31, 2017.
- Provide supporting cost report documentation including, but not limited to, the working trial balance, financial statements, Medicare bad debt listing, interns and residents information system data, and so on.
- Submit the MCR package to their MAC via mail (or hand delivery), which account for 91 percent of all MCR submissions, or a hybrid of mail and electronic submissions which account for 9 percent of total submissions. The signed worksheet S must be mailed to the MAC.

Streamlined the MCR filing process:

To streamline the MCR filing process, the 2018 inpatient prospective payment system (IPPS) final rule allows for an electronic signature on the MCR worksheet S (certification page) for cost reports ending on or after December 31, 2017. Additionally, beginning May 1, 2018, CMS will make the MCReF system available to Part A providers for electronic transmission (e-filing) of an MCR package directly to a MAC. A CMS enterprise identity management (EIDM) account is required to use MCReF, which is the same account providers use to order copies of their provider statistical and reimbursement reports (PS&R).

Upon login, providers will be able to select the fiscal year end for which they are filing, upload all corresponding MCR materials as attachments, and submit the documents directly to their MAC. The system will perform a basic review of the attached materials to determine if the MCR is "receivable" (See Attachment A of CR 10611. The Web address of CR 10611 is in the *Additional information* section of this article.). If issues are identified, the provider will immediately receive an error/warning message. If no issues are identified, the provider will receive a confirmation number, as well as an electronic postmark date, which can be used in correspondence regarding the submission. Once the cost report is deemed "receivable," the MAC will perform the acceptability review within 30 days. The MAC will issue a rejection letter if the cost report is rejected.

Medicare cost report e-filing (MCReF) system access:

MCReF will be hosted at the following URL: *https://mcref.cms.gov*. System access to MCReF will be controlled by

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

Document history

Date of change	Description
April 27, 2018	Initial article released.

MLN Matters® Number: MM10457

Related CR Release Date: April 27, 2018
Related CR Transmittal Number: R304FM and R4039CP
Related Change Request (CR) Number: 10457
Effective Date: October 1, 2018
Implementation Date: October 1, 2018

MCReF

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the EIDM system, as previously noted. Part A provider security officials (SOs) and their backups (BSOs), already registered in EIDM for access to CMS PS&R, will inherit access to MCReF by default through their existing account.

Providers that are not registered in EIDM, but wish to gain access to MCReF, must register in EIDM and assign an SO for their organization. New user registration is available at *https://portal.cms.gov/wps/portal/unauthportal/eidm/newuserregistration*.

Note: It is important for providers to keep their EIDM credentials in good standing to avoid problems using MCReF to e-file cost reports and obtaining PS&R. This includes password updates per CMS policy and the timely replacement of SOs due to staffing changes. Issues with maintaining EIDM credentials will not constitute a valid reason for filing a cost report past its due date.

Starting July 2, 2018, providers that wish to e-file their MCR must use MCReF. MAC portals will no longer be an acceptable means of submission. Providers that wish to mail or hand deliver MCRs to MACs, may continue to do so.

Benefits of streamlined MCR processes:

- Increases CMS access to MCR data as submitted by providers to assist with responding to inquiries and remove additional administrative burdens on MACs and CMS.
- Eliminates MAC processes for populating the CMS Healthcare Cost Reporting Information System (HCRIS) – including the submission of 100,000 cost reports to HCRIS and subsequent resubmission.
- Eliminates the need for MACs to enter MCR postmarked date, received date, and HCRIS sent date.
- Enables direct receipt/promotion of IRIS data to its required end-state in STAR (eliminates manually upload IRIS data).
- Large provider chain organizations will electronically submit MCRs to one system instead of transmitting their MCRs to their assigned MAC jurisdiction's portals or physical mailing addresses.
- An MCR submitted through MCReF will be directed automatically to the correct MAC eliminating the risk of submitting the MCR to an incorrect MAC.
- Providers will receive immediate feedback on whether the MCR is received.
- Providers will save time compiling the paperwork (files) needed to create electronic media and mail the MCR package;
- Providers will have until 11:59 p.m. eastern time on the due date to submit the MCR through MCReF.

- MCReF has a simple, straightforward user interface with just one screen.
- Reduces provider confusion due to conflicting MAC "receivability" rules.

Additional information

The official instruction, CR 10611, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2075OTN.pdf*. A detailed MCReF system overview is attached to the CR. CMS encourages cost report staff to review this overview.

Chapter 1 of the *Provider Reimbursement Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.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
May 2, 2018	Initial article released.

MLN Matters® Number: MM10611
Related CR Release Date: April 30, 2018
Related CR Transmittal Number: R2075OTN
Related Change Request (CR) Number: 10611
Effective Date: June 12, 2018
Implementation June 12, 2018

Manual updates to replace remittance advice remark code MA61 with N382

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) 10619 initiates both Medicare manual changes and operational changes related to the new Medicare card. Medicare will replace the use of remittance advice remark code (RARC) MA61, referenced in the *Medicare Claims Processing Manual*, Chapters 1 and 27, with RARC N382 - missing/incomplete/invalid patient identifier (HICN or MBI). Effective for claims processed on or after the effective date of CR 10619, MACs will use N382 in place of MA61 to communicate reject/denials for patient identifiers (HICN or MBI) in all remittance advices and 835 transactions. However, MACs will continue to use RARC MA61 only when/if communicating rejections/denials related to a missing/incomplete/invalid social security number. Make sure your billing staffs are aware of these updates.

Background

With the implementation of the Medicare beneficiary identifier (MBI), references to the health insurance claim number (HICN) will be replaced with a more generic reference (patient identifier). CR 16019 initiates the manual changes and operational changes to accomplish this task.

Additional information

The official instruction, CR 10619, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4047CP.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
May 14, 2018	Initial article released.

MLN Matters® Number: MM10619
Related CR Release Date: May 11, 2018
Related CR Transmittal Number: R4047CP
Related Change Request (CR) Number: 10619
Effective Date: August 13, 2018
Implementation August 13, 2018

Your Feedback Matters

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

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.

New LCD

Emergency and non-emergency ground ambulance services – new Part A and Part B LCD

LCD ID number: L37697 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for emergency and non-emergency ground ambulance services was developed based on the following: data analysis, issues identified by the Office of Inspector General (OIG) and postpayment medical review, and to provide a comprehensive document of all the pertinent Medicare regulations pertaining to ground ambulance services. Furthermore, the existing non-emergency ground ambulance services LCD (L33383) will be retired when this new LCD becomes effective.

Effective date

This new LCD is effective for services rendered **on or after June 28, 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*.

Revisions to LCDs

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

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

Based on an annual review of the local coverage determination (LCD) for bone mineral density studies, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity," "CPT®/HCPCS Codes," and "Utilization Guidelines" sections of the LCD do not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

The LCD revision is effective for services rendered **on or after May 1, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Medicare A Connection subscription

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

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

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

Botulinum toxins – revision to the Part A and Part B LCD

LCD ID number: L33274 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the botulinum toxins LCD was revised in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD to include the Food and Drug Administration (FDA) indications for Dysport® –the treatment of spasticity in adults and the treatment of lower limb spasticity in pediatric patients two years of age and older. In addition, the accompanying ICD-10-CM diagnosis codes (G11.4, G80.8, G82.21-G82.22, G82.51-G82.52, G83.11-G83.14, I69.041-I69.044, I69.141-I69.144, I69.241-I69.244, I69.341-I69.344, I69.841-I69.844, M62.451-M62.452, M62.461-M62.462, M62.471-M62.472, M62.48, M62.49, M62.831, and M62.838) for these indications were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD under "Group 2 Codes:" for Healthcare Common Procedure Coding System (HCPCS) code J0586. The "Sources of Information and Basis for Decision" section of the LCD has also been updated.

Effective date

The LCD revision to include the treatment of lower limb spasticity in pediatric patients two years of age and older is effective for claims processed **on or after May 3, 2018**, for services rendered **on or after July 29, 2016.** The LCD revision to include the treatment of spasticity in adults is effective for claims processed **on or after May 3, 2018**, for services rendered **on or after June 14, 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*.

CYP2C19, CYP2D6, CYP2C9, and VKORC1 genetic testing – revision to the Part A and Part B LCD

LCD ID number: L35698 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10515 (April 2018 Update of the Hospital Outpatient Prospective Payment System [OPPS]) and CR 10445 (Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment), the LCD (CYP2C19, CYP2D6, CYP2C9, and VKORC1 Genetic Testing) was revised to add procedure code 0028U.

Effective date

The LCD revision is effective for claims processed **on or after April 2, 2018**, for services rendered **on or after January 1, 2018**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

G-CSF (Neupogen®, Granix™, Zarxio™) – revision to the Part A and Part B LCD

LCD ID number: L34002 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10454 (Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - April 2018 Update), CR 10515 (April 2018 Update of the Hospital Outpatient Prospective Payment System [OPPS]), and CR 10530 (April 2018 update of the Ambulatory Surgical Center [ASC] Payment System), the local coverage determination (LCD) for G-CSF (Neupogen®, Granix™, Zarxio™) was revised to reflect that the descriptor was changed for Healthcare Common Procedure Coding System (HCPCS) code Q5101 in the "CPT®/HCPCS Codes" section of the LCD. In addition, language related to modifier "ZA" with HCPCS code Q5101 was removed as this modifier has been discontinued.

Effective date

The LCD revision is effective for services rendered **on or after April 1, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

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

Based on change request (CR) 10488 (Quarterly update to the Medicare Physician Fee Schedule Database [MPFSDB] - April 2018 Update),CR 10454 (Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - April 2018 Update), CR 10515 (April 2018 Update of the Hospital Outpatient Prospective Payment System [OPPS]), and CR 10530 (April 2018 update of the Ambulatory Surgical Center [ASC] Payment System), the local coverage determination (LCD) for infliximab (Remicade™) was revised to remove Healthcare Common Procedure Coding System (HCPCS) code Q5102 and add HCPCS codes Q5103 and Q5104 in the "CPT®//HCPCS codes" section of the LCD. In addition, the "CPT®/HCPCS codes" section of the LCD was revised to remove language related to modifiers "ZB" and "ZC" with HCPCS code Q5102 as these modifiers have been discontinued.

Effective date

The LCD revision is effective for services rendered **on or after April 1, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Prostatic urethral lift (PUL) – revision to the Part A and Part B LCD

LCD ID number: L36775 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on reconsideration requests of the prostatic urethral lift (PUL) local coverage determination (LCD), the "Sources of Information and Basis for Decision" section of the LCD was updated to add multiple published sources. The content of the LCD has not been changed in response to the reconsideration requests.

Effective date

This revision to the LCD is effective for services rendered **on or after May 15, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

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

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

Effective date

The LCD revision is effective for services rendered **on or after April 24, 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*.

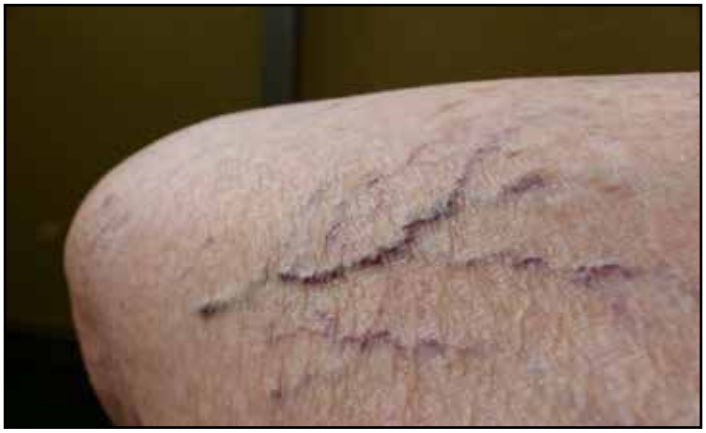
Treatment of varicose veins of the lower extremity – revision to the Part A and Part B LCD

LCD ID number: L33762 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the treatment of varicose veins of the lower extremity local coverage determination (LCD), the "Coverage Indications, Limitations, and/ or Medical Necessity" section of the LCD was revised under "Sclerotherapy" to provide clarification. Also, the "CPT®/HCPCS Codes" section of the LCD under "Group 1 Paragraph" was revised to provide clarification for *Current Procedural Terminology* (CPT®) codes 36470, 36471, 36482, and 36483. In addition, the "Sources of Information" section of the LCD was updated to include multiple published sources from reconsideration requests for CPT® codes 36473 and 36474 (endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical). The content of the LCD has not been changed in response to the reconsideration requests.

Effective date

This revision to the LCD 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, *click here*.

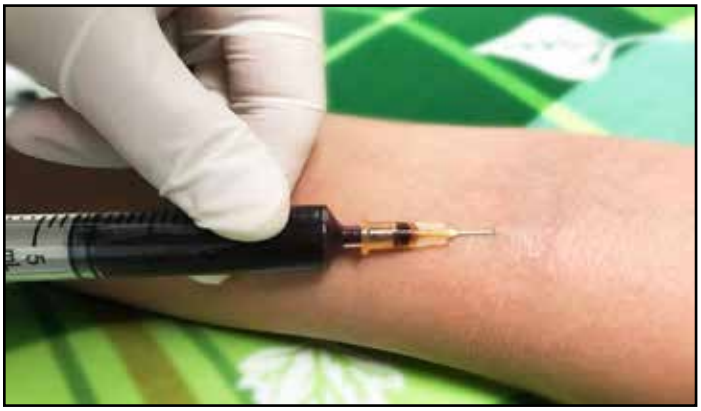
Vitamin D; 25 hydroxy, includes fraction(s), if performed – revision to the Part A and Part B LCD

LCD ID number: L33771 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for vitamin D; 25 hydroxy, includes fraction(s), if performed, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD does not represent direct quotation from a Centers for Medicare & Medicaid Services (CMS) source listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS source.

Effective date

The LCD revision is effective for services rendered **on or after May 15, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.



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

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

Revisions to the telehealth billing requirements for distant site services

Provider type affected

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

Provider action needed

Change request (CR) implements requirements for billing modifier GT for telehealth distant site services. As of January 1, 2018, the GT modifier is only allowed on institutional claims billed by a critical access hospital (CAH) method II. Make sure your billing staffs are aware of this requirement.

Background

Previous guidance instructed providers to submit claims for telehealth services using the appropriate procedure code along with the telehealth modifier GT (via interactive audio and video telecommunications systems). In the 2017 physician fee schedule (PFS) final rule, payment policies regarding Medicare's use of a new place of service (POS) code describing services furnished via telehealth (POS 02) were finalized and implemented through CR 9726. The new POS code became effective January 1, 2017.

In the 2018 PFS final rule, the requirement to use the GT modifier was eliminated for all professional claims. CR10152, which implemented that policy, included a business requirement instructing MACs to be aware that the GT modifier is only allowed for distant site services billed by method II CAHs on type of bill 85x with a revenue code 96x, 97x, or 98x or with a service line that contains HCPCS code Q3014. As of January 1, 2018, the GT modifier is only allowed on institutional claims billed under CAH method II. If the GT modifier is billed by other provider types, the claim line will be rejected with the following remittance codes:

Group code CO - contractual obligation

Claim adjustment reason code 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Start: 01/01/1995 | Last Modified: 07/01/2017

Remittance advice remarks code N519 - Invalid combination of HCPCS modifiers.

Additional information

The official instruction, CR 10583, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4026CP.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 27, 2018	Initial article released.

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Related CR Transmittal Number: R4026CP
Related Change Request (CR) Number: 10583
Effective Date: October 1, 2018
Implementation Date: October 1, 2018

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

Note: *This article was revised March 28, 2018, to link to a MM10312 which is based on change request (CR) 10312. CR 10312 implements the 2018 rate updates for the ESRD prospective payment system (PPS) and updates the payment for renal dialysis services furnished to beneficiaries with acute kidney injury (AKI) in ESRD facilities. All other information remains the same. This information was previously published in the January 2018 Medicare A Connection, pages 13-15.*

Provider types affected

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

Provider action needed

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

Background

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

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

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

Transitional drug add-on payment adjustment

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

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

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

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

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

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

Parsabiv example

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

$2450/ 14 = $175

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

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

$418.63 = $425 * 0.985

The final per treatment payment rate is $418.63

Sensipar example

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

1/1/2018 REV 821

1/3/2018 REV 821

1/5/2018 REV 821

1/8/2018 REV 821

1/10/2018 HCPCS J0604, 660 units

1/10/2018 REV 821

1/12/2018 REV 821

1/15/2018 REV 821

1/17/2018 REV 821

1/19/2018 REV 821

1/22/2018 REV 821

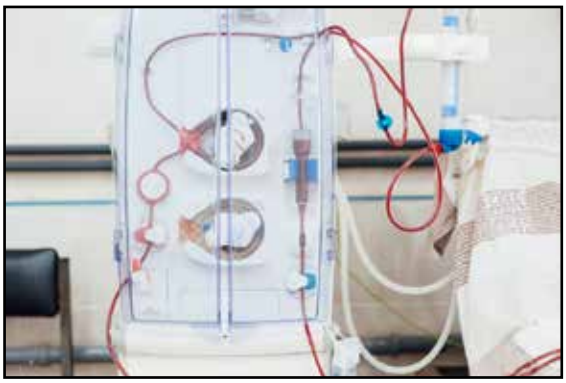
1/24/2018 REV 821

1/26/2018 REV 821

1/29/2018 REV 821

1/31/2018 REV 821

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



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

$660/ 14 = $47.14

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

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

$292.68 = $297.14 * 0.985

The final per treatment payment rate is $292.68

Oral or other forms of injectable drugs and biologicals

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

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

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

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

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however, CMS does expect facilities to be aware of the patient's plan of care and know the medications the patient was instructed to take for the claim's time period, and ensure the claim reflects that plan of care.

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

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

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

Additional information

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

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

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

Document history

Date of change	Description
March 28, 2018	This article was revised to link to a *MM10312* which is based on change request (CR) 10312. CR 10312 implements the 2018 rate updates for the ESRD prospective payment system (PPS) and updates the payment for renal dialysis services furnished to beneficiaries with acute kidney injury (AKI) in ESRD facilities.
January 10, 2018	The article was revised to provide more descriptive examples in the *Background* section for Parsabiv and Sensipar. The CR release date, transmittal number and the web address for accessing the CR were revised also. All other information remains the same.
December 29, 2017	The article was revised December 29, 2017, in order to add the section titled *Oral or other forms of injectable drugs and biologicals* in the *Background* section.
August 9, 2017	Initial article released

MLN Matters® Number: MM10065 *Revised*
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Related Change Request (CR) Number: CR 10065
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Comprehensive ESRD care (CEC) model telehealth – implementation

Provider type affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers billing Medicare administrative contractors (MACs) and participating in the comprehensive ESRD care (CEC) model for telehealth services provided to Medicare end-stage renal disease (ESRD) beneficiaries associated with the CEC model.

Provider action needed

Change request (CR) 10314 details the CEC model telehealth program and how it will be implemented. Make sure your billing staffs are aware of this initiative.

Background

Section 1115A) of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act (ACA) (42 USC 1315a) authorizes the Center for Medicare and Medicaid Innovation (CMMI) to test innovate health care payment and service-delivery models that have the potential to lower Medicare, Medicaid, and the Child Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

The CEC model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with ESRD. Through the CEC model, the Centers for Medicare & Medicaid Services (CMS) will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing beneficiaries with person-centered, high-quality care. The model builds on accountable care organization (ACO) experience from the pioneer ACO model, next generation ACO model, and the Medicare shared savings program to test ACOs for ESRD beneficiaries.

More than 600,000 Americans have ESRD and require life-sustaining dialysis treatments several times per week. Many beneficiaries with ESRD suffer from poorer health outcomes, often the result of underlying disease complications and multiple co-morbidities. These can lead to high rates of hospital admission and readmissions, as well as a mortality rate that is higher than that of the general Medicare population.

According to United States Renal Data System, in 2014, ESRD beneficiaries comprised less than 1 percent of the Medicare population, but accounted for an estimated 7.2 percent of total Medicare fee-for-service (FFS) spending, totaling more than $32.8 billion.

Because of their complex health needs, beneficiaries often require visits to multiple providers and follow multiple care plans, all of which can be challenging for beneficiaries if care is not coordinated. The CEC model seeks to create incentives to enhance care coordination and to create a person-centered, coordinated care experience, and to ultimately improve health outcomes for this population.

In the CEC model, dialysis clinics, nephrologists and other providers collaborate to create an ESRD seamless care organization (ESCO) to coordinate care for matched beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes measured by Medicare Part A and B spending, including all spending on dialysis services for their aligned ESRD beneficiaries. This model encourages dialysis providers to think beyond their traditional roles in care delivery and supports them as they provide patient-centered care that will address beneficiaries' health needs, both in and outside of the dialysis clinic.

The CEC model includes separate financial arrangements for larger and smaller dialysis organizations. Large dialysis organizations (LDOs), defined as having 200 or more dialysis facilities, will be eligible to receive shared savings payments. These LDOs will also be liable for shared losses and will have higher overall levels of risk compared with their smaller counterparts.

Non-large dialysis organizations (Non-LDOs) include chains with fewer than 200 dialysis facilities, independent dialysis facilities, and hospital-based dialysis facilities. Non-LDOs will have the option of participating in a one-sided track where they will be able to receive shared savings payments, but will not be liable for payment of shared losses, or participating in a track with higher risk and the potential for shared losses. The one-sided track is offered in recognition of the non-LDOs more limited resources.

The CEC model began October 1, 2015, and will run until December 31, 2020. The CEC model conducted a solicitation in 2016 to add more ESCOs for performance year two of the model, beginning January 1, 2017. The CEC model has no current plans for another round of solicitations.

The CEC model LDO payment track and non-LDO two-sided payment track are considered advance payment models (APMs) regarding the quality payment program.

The CEC model will implement design elements with implications for the FFS system for its third performance year that includes benefit enhancements to give ACOs the tools to direct care and engage beneficiaries in their own care. The model also offers increased monitoring to account for different financial incentives and the provision of enhanced benefits. The model's quality requirements are similar to shared savings program (SSP) and pioneer, modified as needed to take into account unique aspects of dialysis care, in keeping with the agencies initiatives to unify and streamline quality measurement and requirements.

Telehealth waiver

In order to emphasize high-value services and support the ability of ESCOs to manage the care of beneficiaries, CMS plans to design policies and use the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain

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Medicare payment requirements as part of the CEC model.

CMS will make available to qualified ESCOs a waiver of the originating site requirement for services provided via telehealth. This benefit enhancement will allow beneficiaries to receive qualified telehealth services in non-rural locations and locations that are not specified by statute, such as homes and dialysis facilities. The waiver will apply only to eligible aligned beneficiaries receiving services from ESCO providers.

An aligned beneficiary will be eligible to receive telehealth services through this waiver if the services are otherwise qualified with respect to:

1) The service provided, as designated by *Current Procedural Terminology* (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes, and

2) The remote site.

MACs will apply claims processing edit logic, audit, medical review, Medicare secondary payor, and fraud and abuse activities, appeals and overpayment processes for CEC claims in the same manner as normal FFS claims.

Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under Section 1834(m)(4)(F) of the Act, and subsequent additional services specified through regulation with the exception that claims **will not** be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or skilled nursing facilities (SNFs) - HCPCS codes G0406-G0408.
- Subsequent hospital care services, with the limitation of one telehealth visit every three days - CPT® codes 99231-99233.
- Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days - CPT® codes 99307-99310.
- Telehealth consultations, emergency department or initial inpatient - HCPCS codes G0425-G0427.
- Telehealth consultation, critical care, initial - HCPCS code G0508.
- Telehealth consultation, critical care, subsequent - HCPCS code G0509.
- Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service - CPT® codes 99356-99357.

MACs will be ready to process Part B CEC claims for dates of service on or after October 1, 2018. MACs will process CEC telehealth claims (place of service (POS) 02)

when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the date of service (DOS) on the claims and contains the demo code 85 and one of the following CPT® or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

For Part A CEC claims when providers are ESCO providers and beneficiaries are aligned to the same ESCO for the date of service (DOS) on the claims submitted on type of bill (TOB) 12x, 13x, 22x, 23x, 71x, 72x, 76x, 77x, or 85x and contains the demo code 85 and one of the following CPT® or HCPCS codes:

90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 96116, 96150, 96151, 96152, 96153, 96154, 96160, 96161, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, 99355, 99406, 99407, 99495, 99496, 99497, 99498, G0108, G0109, G0270, G0396, G0397, G0420, G0421, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0459, G0506, G9481, G9482, G9483, G9484, G9485, G9486, G9487, G9488, G9489

MACs will not process as CEC telehealth claims that contain the following codes. Claims that contain these codes these codes can be processed following existing claim processing logic:

- HCPCS codes G0406 – G0408.
- CPT® codes 99231 – 99233.

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- CPT® codes 99307 – 99310.
- HCPCS codes G0425-G0427
- HCPCS code G0508
- HCPCS code G0509
- CPT® codes 99356-99357

MACs will treat CEC payments the same as Medicare patients for cost reporting purposes.

Providers submitting electronic 837 claims should enter DEMO 85 in the REF segment 2300 loop demonstration project identifiers and providers will include qualifier P4. Providers submitting a paper claim should enter demo 85 in the treatment authorization field.

Providers should be aware that MACs will return claims if you append demo code 85, and:

- You are not on the CEC participant provider list with a telehealth record type; or
- DOS "from date" is prior to your telehealth effective date, or
- DOS "from date" is after your telehealth termination date, or
- The DOS "from date" is prior to the beneficiary's effective date; or
- The DOS "from date" is after the beneficiary's termination date, or
- The DOS "from date" is more than 90 days after the beneficiary's termination date; or
- The beneficiary was not aligned to the same ESCO with which you are participating, as identified by ESCO ID; or
- The claim is for Part A and the TOB is other than 12x, 13x, 22x, 23x, 71x, 72x, 76x, 77x, and 85x,
- Other, non-telehealth services are billed on the same claim. In these cases, none of the services on the claim are processed.

In returning Part B claims, your MAC will use the following messaging:

- Claims adjustment reason code (CARC) 16: (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication) and
- Remittance advice remark code (RARC) N763 (The demonstration code is not appropriate for this claim; resubmit without a demonstration code.)
- Group code: CO (contractual obligation)

For Part A claims, your MAC will just return the claim to the provider (RTP).

Additional information

The official instruction, CR 10314, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R196DEMO.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 27, 2018	Initial article released.

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Changes to the ESRD facility claim to accommodate dialysis furnished to beneficiaries with acute kidney injury

***Note**: This article was revised May 18, 2018 to update language in the "Background" section. The non-ESRD HCPCS codes and ESRD modifiers were updated. All other information is unchanged. This information was previously published in the June 2017 Medicare A Connection, pages 17-19.*

Provider type affected

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

What you need to know

Change request (CR) 9598 implements changes to the ESRD facility claim (type of bill 72x) to accommodate dialysis furnished to beneficiaries with acute kidney injury (AKI). This *MLN Matters*® article summarizes these changes. Make sure that your billing staffs are aware of these changes.

Background

On June 29, 2015, The Trade Preferences Extension Act of 2015 was enacted in which Section 808 amended Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under Section 1881(b)(14) to beneficiaries with AKI effective January 1, 2017.

Beginning January 1, 2017, ESRD facilities will be able to furnish dialysis to AKI patients. The AKI provision was signed into law on June 29, 2015. (See *Sec. 808 Public Law 114-27*.)

The provision provides Medicare payment beginning on dates of service January 1, 2017, and after to ESRD facilities, that is, hospital-based and freestanding, for renal dialysis services furnished to beneficiaries with AKI (both adult and pediatric). Medicare will pay ESRD facilities for the dialysis treatment using the ESRD prospective payment system (PPS) base rate adjusted by the applicable geographic adjustment factor, that is, wage index. In addition to the dialysis treatment, the ESRD PPS base rate pays ESRD facilities for the items and services considered to be renal dialysis services as defined in *42 CFR 413.171* and there will be no separate payment for those services.

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

Items and services furnished to beneficiaries with AKI that are not considered to be renal dialysis services as defined in 42 CFR 413.171, are separately payable. Specifically, drugs, biologicals, laboratory services, supplies, and other services that ESRD facilities are certified to furnish and that would otherwise get furnished to a beneficiary with AKI in a hospital outpatient setting will be paid separately using the applicable Part B fee schedule. This includes vaccines. ESRD facilities may provide vaccines to beneficiaries with AKI and seek reimbursement under the applicable CMS vaccination policies discussed in *Chapter 18 of the "Medicare Claims Processing Manual*.

For payment under Medicare, ESRD facilities shall report all items and services furnished to beneficiaries with AKI by submitting the 72x type of bill with condition code 84 - Dialysis for acute kidney injury (AKI) on a monthly basis. Since ESRD facilities bill Medicare for renal dialysis services by submitting the 72x type of bill for ESRD beneficiaries, condition code 84 will differentiate an ESRD PPS claim from an AKI claim. AKI claims will require one of the following diagnosis codes:

1. N17.0 - Acute kidney failure with tubular necrosis
2. N17.1 - Acute kidney failure acute cortical necrosis
3. N17.2 - Acute kidney failure with medullary necrosis
4. N17.8 - Other acute kidney failure
5. N17.9 - Acute kidney failure, unspecified
6. T79.5XXA - Traumatic anuria, initial encounter
7. T79.5XXD - Traumatic anuria, subsequent encounter
8. T79.5XXS - Traumatic anuria, sequela
9. N99.0 - Post-procedural (acute)(chronic) renal failure

In addition, ESRD facilities are required to include revenue code 082x, 083x, 084x, or 085x for the modality of dialysis furnished with the HCPCS code G0491 (Long descriptor – *Dialysis procedure at a Medicare certified ESRD facility for Acute Kidney Injury without ESRD*; short descriptor – dialysis Acu Kidney no ESRD). Beneficiaries with AKI are able to receive either peritoneal dialysis or hemodialysis in an ESRD facility. Based on the level of care required for these beneficiaries, at this time, CMS is not extending the home dialysis benefit to beneficiaries with AKI.

AKI claims will not have limits on how many dialysis treatments can be billed for the monthly billing cycle, however, there will only be payment for one treatment per day across settings, except in the instance of uncompleted treatments. If a dialysis treatment is started, that is, a patient is connected to the machine and a dialyzer and blood lines are used, but the treatment is not completed for some unforeseen, but valid reason, the facility is paid based on the full base rate. An example includes medical

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emergencies such as rushing a dialysis patient to an emergency room mid-treatment. This is a rare occurrence and must be fully documented to your MAC's satisfaction.

Applicability of other ESRD and CMS adjustments

ESRD network fee

The ESRD network fee reduction **is not** applicable to claims for beneficiaries with AKI. The operationalization of this policy occurs via CR 9814 effective April 1, 2017, and claims submitted between January 1, 2017, and March 31, 2017, will be adjusted once the CR is implemented.

ESRD quality incentive program (QIP)

The ESRD QIP is not applicable for beneficiaries with AKI at this time.

Sequestration adjustments

The two percent sequestration adjustment is applicable to claims for beneficiaries with AKI. This is a global CMS adjustment and as such applies to AKI claims.

ESRD conditions for coverage (CfCs)

The ESRD CfCs at 42 CFR part 494 are health and safety standards that all Medicare participating dialysis facilities must meet. These standards set baseline requirements for patient safety, infection control, care planning, staff qualifications, record keeping, and other matters to ensure that all patients, including ESRD and AKI patients, receive safe and appropriate care.

Low volume payment adjustment (LVPA)

AKI dialysis treatments count toward the LVPA threshold when determining total number of treatments provided when a facility prepares the low volume attestation to determine eligibility for the LVPA, however, claims for patients with AKI will not receive the adjustment.

Home or self-dialysis training add-on payment adjustment

The home or self-dialysis training add-on is not applicable to claims for treatments provided to patients with AKI.

Billing for physicians' services for patients with AKI

Physicians are able to bill separately for services provided to patients with AKI. CMS expects providers to follow correct coding guidelines and use the appropriate HCPCS or CPT® codes for the items and services provided to the patient.

The following CPT® codes are available for ESRD facilities and physician's offices to use when billing for physicians' services provided in either an ESRD facility (place of service 65) or a physician's office (place of service 11):

- 90935 - Hemodialysis procedure with single evaluation by a physician or other qualified health care professional
- 90937 - Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription
- 90945 - Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous replacement therapies), with single evaluation by a physician or other qualified health care professional
- 90947 - Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription

Please note: this is not an exhaustive list – as indicated above, CMS expects facilities and physician's offices to bill the appropriate codes.

Payment for erythropoietin stimulating agents (ESAs) and the ESA monitoring policy for AKI patients

ESAs are included in the bundled payment amount for treatments administered to patients with AKI. The non-ESRD HCPCS codes should be used (J0881, J0883, J0885, J0888, and Q0138). This policy was implemented with CR 9987.

The ESA monitoring policy has not yet been extended to AKI patients receiving treatment in an ESRD facility. Since this policy is not applicable to these treatments, the value codes used to report hemoglobin and hematocrit levels are not required when billing for ESAs.

Telehealth

Unless other criteria are met, telehealth is only available for ESRD beneficiaries at this time. Please see *https://www.cms.gov/Outreach-and-Education/Medicare-Learning- Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf*.

Modifier, value code, condition code, and occurrence codes

- Urea reduction ratio and vascular access modifiers are not required on ESRD facility claims for patients with AKI.
- ESRD specific modifiers, including JA, JB, and JE should not be included on AKI claims.
- ESRD facilities are not required to report the Kt/v reading value or the date of the last reading (occurrence code 51) for patients with AKI.
- ESRD facilities are not required to report a patient's height and weight (value codes A8 and A9) for patients with AKI.

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Additional information

The official instruction, CR 9598, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/Downloads/R1759OTN.pdf*.

The official instruction, CR 9987, issued to your MAC regarding this change is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9987.pdf*.

MLN Matters® article MM9807 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9807.pdf*.

42 CFR 413.171 is available at *https://www.ecfr.gov/cgi-bin/retrieveECFR?gp&SID=3233ff9c843c3f74275cab5dcbcf088c&mc=true&n=pt42.2.413&r=PART&ty=HTML&se42.2.413_1171*.

42 CFR 494 is available at *https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol5/CFR-2011-title42-vol5-part494*.

The Trade Preferences Extension Act of 2015 is available at *https://www.congress.gov/bill/114th-congress/house-bill/1295/text#toc-HEE69B51CC87340E2B2AB6A4FA73D2A82*.

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

The 2017 proposed rule is available at *https://www.gpo.gov/fdsys/pkg/FR-2016-06-30/pdf/2016-15188.pdf*

The 2017 final rule is available at *https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-26152.pdf04/pdf/2016-26152.pdf*.

Document history

Date of change	Description
May 18, 2018	This article was revised to update language in the *Background* section. The non-ESRD HCPCS codes and ESRD modifiers were updated.
November 21, 2017	This article was revised to add a link to *MM10281*. That article updates the AKI payment policy regarding transitional drug add-on payment adjustments (TDAPA).
June 19, 2017	This article was revised June 19, 2017, to refer to code G0491 as a HCPCS code rather than a CPT® code. In addition, a clarification was made in the paragraphs relating to the ESRD conditions of coverage and the low volume payment adjustment. Information regarding home or self-dialysis training add-on payment adjustments, billing for physician services, payment for erythropoietin stimulating agents, telehealth, and modifiers, value codes, condition codes, and occurrence codes is also added in the *Background* section.
March 7, 2017	The article was revised to add a link to *MLN Matters*® article *MM9807* which implements the payment for renal dialysis services furnished to beneficiaries with AKI in ESRD facilities for 2017. All other information is unchanged.
December 7, 2016	Article released.

MLN Matters® Number: MM9598 *Revised*
Related CR Release Date: December 6, 2016
Related CR Transmittal Number: R1759OTN
Related Change Request (CR) Number: 9598
Effective Date: January 1, 2017
Implementation January 3, 2017

Update the identification code qualifier being used in the NM108 data element

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) 10565 provides instructions to the MACs to update the identification code qualifier in data element NM108 currently being used in the 2100 loop, NM1- patient name segment of the 835 guide. This will synchronize the usage of the same qualifier as used/submitted on the claim. Make sure your billing staffs are aware of these instructions.

Background

With the removal of the Social Security number (SSN)-based health insurance claim number (HICN) from Medicare cards and in an effort to synchronize the usage of the same identification code qualifier in the health care claim payment/advice (835) and the professional and institutional (837) health care claim as required by the 835 guide, CR 10565 modifies the identification code qualifier being used in the 835 electronic remit from HN to MI.

Additional information

The official instruction, CR 10565, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2063OTN.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 27, 2018	Initial article released.

MLN Matters® Number: MM10565
Related CR Release Date: April 27, 2018
Related CR Transmittal Number: R2063OTN
Related Change Request (CR) Number: 10565
Effective Date: October 1, 2018 – not based on date of service
Implementation Date: October 1, 2018

CORE 360 uniform use of CARC, RARC and CAGC rule

Provider type affected

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

Provider action needed

Change request (CR) 10566 informs MACs to update their systems based on the CORE 360 Uniform use of claims adjustment reason codes (CARC), remittance advice remark codes (RARC) and claim adjustment group code (CAGC) rule publication. These system updates are based on the Committee on Operating Rules for Information Exchange (CORE) code combination list to be published on or about June 4, 2018. CR 10566 applies to the *Medicare Claims Processing Manual*, Chapter 22, Section 80.2. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (DHHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, electronic funds transfer (EFT) and electronic remittance advice (ERA) operating rule set that was implemented January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by

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mandating the adoption of a set of operating rules for each of the HIPAA transactions.

CR 10566 deals with the regular update in CAQH CORE defined code combinations per operating rule 360 - uniform use of CARC and RARC (835) rule.

CAQH CORE will publish the next version of the code combination list on or about June 4, 2018. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2018. This will also include updates based on market based review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare, as the industry needs them.

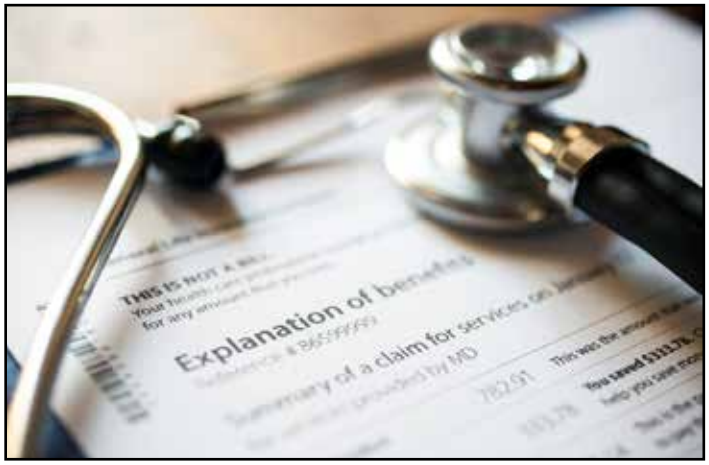
See *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

Note: As the Affordable Care Act requires, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four (4) business scenarios. Medicare can use any code combination if the business scenario is not one of the four (4) CORE defined business scenarios. With the four (4) CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 10566, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4054CP.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
May 18, 2018	Initial article released.

MLN Matters® Number: MM10566
Related CR Release Date: May 18, 2018
Related CR Transmittal Number: R4054CP
Related Change Request (CR) Number: 10566
Effective Date: October 1, 2018
Implementation October 1, 2018

New MBI lookup available

The Secure Provider Online Tool (SPOT) is able to look up the new Medicare beneficiary identifiers (MBIs) belonging to all Medicare beneficiaries. This allows providers to enter information on a beneficiary and receive that beneficiary's new MBI. In preparation for the new Medicare cards, distribution of cards to those who live in Florida, Puerto Rico, and the U.S. Virgin Islands began in June.

CMS Proposes 4 Rules Affecting FY19 Payment & Quality Programs

Skilled Nursing Facility: Proposed FY 2019 Payment and Policy Changes

Inpatient Rehabilitation Facility: Prospective Payment System FY 2019 Proposed Rule

Inpatient Psychiatric Facility: FY 2019 Payment and Quality Reporting Updates

Hospice: Proposed Updates to the Wage Index and Payment Rates for FY 2019

Skilled Nursing Facility: Proposed FY 2019 Payment and Policy Changes

CMS issued a proposed rule outlining proposed FY 2019 Medicare payment updates and proposed quality program changes for Skilled Nursing Facilities (SNFs).

Proposed Rule Details:

- Advancing My HealthEData: Request for Information from stakeholders
- Modernizing the SNF Prospective Payment System (PPS) Case-mix Classification System
- SNF Quality Reporting Program (QRP)
- SNF Value-Based Purchasing Program (VBP)
- Payment rate changes under SNF PPS

For More Information:

- *Proposed Rule*: CMS will accept comments until June 26
- *Press Release*
- *SNF PPS website*
- *SNF QRP website*
- *IMPACT Act of 2014 Data Standardization & Cross Setting Measures webpage*
- *SNF VBP Program website*

See the full text of this excerpted *CMS Fact Sheet* (issued April 27).

Inpatient Rehabilitation Facility: Prospective Payment System FY 2019 Proposed Rule

On April 27, CMS proposed changes on how Medicare pays Inpatient Rehabilitation Facilities (IRFs) to make it easier for providers to spend more time with their patients and improve the use of electronic health records.

Proposed Rule Details:

- Advancing My HealthEData: Request for Information from stakeholders
- Burden reduction / Patients over Paperwork
- Meaningful Measures
- Proposed updates to IRF payment rates
- Solicitation of comments regarding additional changes to the physician supervision requirement

For More Information:

- *Proposed Rule*: CMS will accept comments until June 26
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (issued April 27).

Inpatient Psychiatric Facility: FY 2019 Payment and Quality Reporting Updates

On April 27, CMS issued a rule proposing updates for FY 2019 to Medicare payment policies and rates for the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) and the IPF Quality Reporting Program.

- Proposed Rule Details:
- Advancing My HealthEData: Request for Information from stakeholders
- Meaningful Measures
- Proposed payment updates
- Proposed technical corrections to IPF regulations
- IPF PPS refinements comment solicitation

For More Information:

- *Proposed Rule*: CMS will accept comments until June 26
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (issued April 27).

Hospice: Proposed Updates to the Wage Index and Payment Rates for FY 2019

On April 27, CMS issued a proposed rule that would update FY 2019 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. This rule also proposes changes to the Hospice Quality Reporting Program.

- Proposed Rule Details:
- Advancing My HealthEData: Request for Information from stakeholders
- Burden reduction
- Meaningful Measures
- Routine annual rate setting changes
- Hospice regulations text changes due to the Bipartisan Budget Act of 2018
- Improving transparency for patients

For More Information:

- *Proposed Rule*: CMS will accept comments until June 26
- *Press Release*

See the full text of this excerpted *CMS Fact Sheet* (issued April 27).

CMS Proposes Changes to Empower Patients and Reduce Administrative Burden

Changes in IPPS and LTCH PPS would advance price transparency and interoperability

On April 24, CMS proposed changes to empower patients through better access to hospital price information, improve patients' access to their electronic health records, and make it easier for providers to spend time with their patients. The proposed rule proposes updates to Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS).

"We seek to ensure the health care system puts patients first," said Administrator Seema Verma. "Today's proposed rule demonstrates our commitment to patient access to high quality care while removing outdated and redundant regulations on providers. We envision a system that rewards value over volume and where patients reap the benefits through more choices and better health outcomes. Secretary Azar has made such a value-based transformation in our health care system a top priority for HHS, and CMS is taking important, concrete steps toward achieving it."

The policies in the IPPS and LTCH PPS proposed rule would further advance the agency's priority of creating a patient-driven health care system by achieving greater price transparency and interoperability – essential components of value-based care – while also significantly reducing the burden for hospitals so they can operate with better flexibility and patients have the information they need to become active health care consumers.

While hospitals are already required under guidelines developed by CMS to either make publicly available a list of their standard charges, or their policies for allowing the public to view a list of those charges upon request, CMS is updating its guidelines to specifically require that hospitals post this information. The agency is also seeking comment on what price transparency information stakeholders would find most useful and how best to help hospitals create patient-friendly interfaces to make it easier for consumers to access relevant health care data so they can more readily compare providers.

The proposed policies begin implementing core pieces of the government-wide MyHealthEData initiative through steps to strengthen interoperability or the sharing of health care data between providers. Specifically, CMS is proposing to overhaul the Medicare and Medicaid Electronic Health Record Incentive Programs (also known as the "Meaningful Use" program) to:

- Make the program more flexible and less burdensome
- Emphasize measures that require the exchange of health information between providers and patients
- Incentivize providers to make it easier for patients to obtain their medical records electronically

To better reflect this new focus, we are renaming the Meaningful Use program "Promoting Interoperability." In addition, the proposed rule reiterates the requirement for providers to use the 2015 Edition of certified electronic health record technology in 2019 as part of demonstrating meaningful use to qualify for incentive payments and avoid reductions to Medicare payments. This updated technology includes the use of application programming interfaces, which have the potential to improve the flow of information between providers and patients. In the proposed rule, CMS is requesting stakeholder feedback through a Request for Information on the possibility of revising Conditions of Participation to revive interoperability as a way to increase electronic sharing of data by hospitals.

As part of its commitment to burden reduction, CMS is proposing in the FY 2019 IPPS/LTCH PPS proposed rule to remove unnecessary, redundant, and process-driven quality measures from a number of quality reporting and pay-for-performance programs. The proposed rule would eliminate a significant number of measures acute care hospitals are currently required to report and remove duplicative measures across the 5 hospital quality and value-based purchasing programs. This would remove 19 measures from the programs and de-duplicate another 21 measures while still maintaining meaningful measures of hospital quality and patient safety. Additionally, CMS is proposing a variety of other changes to reduce the number of hours providers spend on paperwork. CMS is proposing this new flexibility so that hospitals can spend more time providing care to their patients thereby improving the quality of care their patients receive.

In sum, this results in the elimination of 25 measures across the 5 programs with well over 2 million burden hours reduced for hospital providers impacted by the IPPS proposed rule, saving them $75 million.

For More Information:

- *Proposed Rule*
- *Fact Sheet*

See the full text of this excerpted *CMS Press Release* (issued April 24).

Inpatient prospective payment system and long-term care hospital PPS extensions

Provider type affected

This *MLN Matters*® article is intended for hospitals that submit claims to Medicare administrative contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries by short term acute care and long-term care hospitals (LTCHs).

Provider action needed

Change request (CR) 10547 provides information and implementation instructions for Sections 50204, 50205, and 51005 of the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act of 2018. Make sure that your billing staffs are aware of these changes.

Background

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (see *https://www.gpo.gov/fdsys/pkg/BILLS-115hr1892enr/pdf/BILLS-115hr1892enr.pdf*). The new law includes the extension of certain provisions that had expired October 1, 2017. Specifically, the following Medicare inpatient prospective payment system (IPPS) and LTCH prospective payment system (PPS) fee-for-service policies have been extended.

Section 50204 – Extension of Increased Inpatient Hospital Payment Adjustment for Certain Low-Volume Hospitals

The Affordable Care Act and subsequent legislation provided for temporary changes to the low-volume hospital adjustment for fiscal years (FYs) 2011 through 2017. To qualify, the hospital must have less than 1,600 Medicare discharges and be located 15 miles or more from the nearest subsection (d) hospital. Section 50204 of the Bipartisan Budget Act of 2018 extends these temporary changes through FY 2018 (and provides for modified temporary changes through FY 2022).

Section 50205 – Extension of the Medicare-Dependent Hospital (MDH) Program

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The Affordable Care Act and subsequent legislation had authorized the MDH program through September 30, 2017. Section 50205 of the Bipartisan Budget Act of 2018 extends the MDH program for discharges occurring on or after October 1, 2017, through FY 2022 (that is, for discharges occurring on or before September 30, 2022).

Section 51005 – Adjustments to the LTCH Site Neutral Payment Rate

Section 1206(a) of the Bipartisan Budget Act of 2013 established patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015. LTCH cases meeting specific clinical criteria are paid the LTCH PPS standard Federal rate payment and those cases not meeting specific clinical criteria are paid the site neutral rate payment. The Bipartisan Budget Act of 2013 provided for a transition period to the site neutral payment rate discharges occurring in cost reporting periods beginning in FY 2016 and FY 2017. Section 51005 of the Bipartisan Budget Act of 2018 extends the blended payment rate for LTCH site neutral payment rate discharges that occur in cost reporting periods beginning in FY 2018 and FY 2019, and adjusts the site neutral payment rate by reducing the IPPS comparable amount by 4.6 percent for FYs 2018 through 2026.

Low-volume hospitals – criteria and payment adjustments for FY 2018

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2018, in accordance with the existing regulations at Section 412.101(b)(2)(ii) (see *https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1101*) and consistent with implementation of the those changes in FYs 2011 and 2017, the Centers for Medicare & Medicaid Services (CMS) intends to publish a notice in the *Federal Register* updating the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) for FY 2018. Implementation of the extension of this temporary change in the low-volume hospital payment adjustment for FY 2018 provided by Section 50204 of the Bipartisan Budget Act of 2018 generally follows the established process that was used for FYs 2011 and 2017. (For additional information on the established process, refer to the FY 2017 IPPS/LTCH PPS final rule (81 FR 56941 through 56943))

Specifically, the number of Medicare discharges for purposes of the low-volume hospital adjustment for FY 2018 is determined in a manner consistent with how it was done for FY 2011 through FY 2017. During that time, the number of Medicare discharges used to establish the discharge criterion and the applicable low-volume percentage adjustment for qualifying hospitals were determined by Table 14, a list of IPPS hospitals with fewer than 1,600 Medicare discharges and their number of Medicare discharges according to the most recent available data published in the corresponding IPPS/LTCH PPS final rule. In the case of FY 2018, the corresponding most recent available data at the time CMS developed the FY 2018 IPPS/LTCH final rule was the March 2017 update of the FY 2016 Medicare provider analysis and review (MedPAR) file.

A file that lists the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2017 update of the FY 2016 MedPAR files (MAC implementation file six) is available on the FY 2018 MAC implementation files webpage at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-*

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Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-MAC-Implementation.html. (CMS issued CMS-1677-N Table 1, a list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2017 update of the FY 2016 MedPAR files in conjunction with the notice in the *Federal Register* published April 26, 2018, In lieu of Table 14 of the FY 2018 IPPS/LTCH PPS final rule. CMS-1677-N Table 1 is available on the FY 2018 final rule tables webpage at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html*.)

In order to facilitate administrative implementation, consistent with historical practice, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume adjustment for FY 2018 is the data from the March 2017 update of the FY 2016 MedPAR file. CMS notes that CMS-1677-N Table 1 is a list of IPPS hospitals with fewer than 1,600 Medicare discharges and is not a listing of the hospitals that qualify for the low-volume adjustment for FY 2018, since it does not reflect whether or not the hospital meets the mileage criterion (that is, generally the hospital must also be located more than 15 road miles from any other subsection (d) hospital). **In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2018 discharges, a hospital must meet both the discharge and mileage criteria.**

In order to receive a low-volume adjustment for FY 2018, consistent with the previously established process (described in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56941 through 56943)), CMS is continuing to require a hospital to provide written notification to its MAC. Such notification must contain sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria so that the MAC can determine if the hospital qualifies as a low-volume hospital in accordance with existing requirements set forth in the regulations at Section 412.101(b)(2)(ii) (in conjunction with Section 412.101(e) as applicable). Under this procedure, a hospital receiving the low-volume hospital payment adjustment in FY 2017 may continue to receive a low-volume hospital payment adjustment in FY 2018 without reapplying if it continues to meet both the discharge criterion and the mileage criterion applicable for FY 2018. Such a hospital must send written verification stating that it continues to meet the applicable mileage criterion applicable for FY 2018.

A hospital's written notification must be received by its MAC no later than May 29, 2018, as stated in the notice CMS-1677-N published in the *Federal Register* April 26, 2018 that announced the discharge data source (as mentioned above). If a hospital's request for low-volume hospital status for FY 2018 is received after this date, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the low-volume hospital payment adjustment to determine the payment for the hospital's FY 2018 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

For discharges occurring during FY 2018, if a hospital qualifies as a low-volume hospital, the low-volume hospital indicator field on the provider specific file (PSF) (position 74 – temporary relief indicator) must contain a value of 'Y' and the low-volume payment adjustment factor field on the PSF (positions 252-258) must contain a value greater than zero and less than or equal to 0.250000. (For hospitals that meet both the discharge criterion and the mileage criterion applicable for FY 2018, the value for the low-volume payment adjustment factor field can be found in CMS-1677-N Table 1 as described above). To implement this, the Pricer will apply the applicable low-volume hospital payment adjustment factor from the PSF for hospitals that have a value of 'Y' in the low-volume hospital indicator field on the PSF. Any hospital that does not meet either the discharge or mileage criteria is not eligible to receive a low-volume payment adjustment for FY 2018, and the MAC must update the low-volume hospital indicator field on the PSF (position 74 – temporary relief indicator) to hold a value of "blank."

The applicable low-volume hospital adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, disproportionate share hospital (DSH), uncompensated care, indirect medical education (IME) and outliers. For sole community hospitals (SCHs) and MDHs, the applicable low-volume percentage increase is based on and in addition to either payment based on the federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Extension of the MDH program

Under Section 3124 of the Affordable Care Act, the MDH program authorized by the Social Security Act (§1886(d)(5)(G)) was set to expire at the end of FY 2012. These amendments were extended through September 30, 2017, by subsequent legislation. Section 50205 of the Bipartisan Budget Act of 2018 extends the MDH program, through September 30, 2022. CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in the regulations at §412.108 (see *https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1108*). (For additional information, refer to the FY 2016 Extension of the Low-Volume Hospital Payment Adjustment and MDH Program Interim Final Rule with Comment (IFC) (August 17, 2015; 80 FR 49594 through 49597))

MDH classification in states with no rural area

In addition to extending the MDH program, Section 50205 of the Bipartisan Budget Act of 2018 also provides for hospitals that are located in a state without a rural area (that is, an all-urban state) to be eligible to qualify for MDH status if it otherwise satisfies any of the statutory criteria to be reclassified as rural. Prior to the Bipartisan Budget Act

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of 2018, hospitals could only qualify for MDH status if they were geographically in a rural area or if they reclassified as rural under the statutory provision that is codified in the regulations at 42 CFR 412.103 (see *https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2412_1103*). Under current regulations, hospitals located in all-urban states cannot reclassify as rural because their states do not have rural areas into which they can reclassify. This precluded hospitals in all-urban states from being classified as MDHs. The newly added provision in the Bipartisan Budget Act of 2018 allows a hospital in an all-urban state to be eligible for MDH classification if, among the other criteria, it would have qualified for rural reclassification by meeting the criteria at § 412.103(a)(1) or (3) or the criteria at § 412.103(a)(2) as of January 1, 2018, notwithstanding its location in an all-urban state.

Hospitals in all-urban states looking to qualify for MDH classification should submit the following:

Apply to its regional office as per the application requirements outlined at 42 CFR 412.103(b) to determine if they meet the qualifications for rural reclassification other than being located in an all urban state.

Submit its request for MDH status to its MAC as per the classification procedures under 42 CFR 412.108(b) (the requirements of which are detail below).

A hospital in an all-urban state that qualifies as an MDH under the newly-added statutory provision will not be considered as having reclassified as rural but only as having satisfied one of the criteria at section 1886(d)(8)(E)(ii)(I), (II), or (III) (as of January 1, 2018 as applicable) for purposes of MDH classification.

Reinstatement of MDH status

Consistent with implementation of previous extensions of the MDH program, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective October 1, 2017, with no need to reapply for MDH classification. There are two exceptions:

a. MDHs that classified as SCHs on or after October 1, 2017

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by September 1, 2017, (that is, 30 days prior to the expiration of the MDH program), to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification received SCH status as of October 1, 2017. Additionally, some hospitals that had MDH status as of the October 1, 2017, expiration of the MDH program may have missed the September 1, 2017, application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than October 1, 2017.

b. MDHs that requested a cancellation of their rural classification under §412.103(b)

In order to meet the criteria to become an MDH, generally a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at §412.103. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to October 1, 2017. All other former MDHs will be automatically reinstated as MDHs effective October 1, 2017. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). Specifically, the regulations at Section 412.108(b) require that:

The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (§412.108(b)(2)).

The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (§412.108(b)(3)).

The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital (§412.108(b)(4)).

Cancellation of MDH status

As required by the regulations at Section 412.108(b)(5), MACs must "**evaluate on an ongoing basis**" whether or not a hospital continues to qualify for MDH status. Therefore, as required by the regulations at §412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at §412.108(a) and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the MAC provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2017, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

Notification to provider

Notification to providers is necessary only if there is a change that affects a provider's MDH status; that is, if the provider's MDH status is not reinstated seamlessly from October 1, 2017, because it falls within one of the two exceptions listed above or if the provider will lose its MDH status prospectively due to no longer meeting the criteria for MDH status, per the regulations at §412.108(b)(6).

Hospital specific (HSP) rate update for MDHs

For the payment of FY 2018 discharges occurring on or after October 1, 2017, the hospital-specific (HSP)

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amount for MDHs in the PSF will continue to be entered in FY 2012 dollars. The Pricer will apply the cumulative documentation and coding adjustment factor for FYs 2011-2013 of 0.9480 and apply all updates and other adjustment factors to the HSP amount for FY 2013 and beyond.

Changes to the LTCH site neutral payment rate

Section 51005(a) of the Bipartisan Budget Act of 2018 extends the blended payment rate for LTCH PPS site neutral payment rate cases provided by the Social Security Act (§1886(m)(6)(B)(i)) to discharges occurring in cost reporting periods beginning in FY 2018 and FY 2019. Section 51005(b) of the Bipartisan Budget Act of 2018 reduces the "IPPS comparable amount" component of the site neutral payment rate at §1886(m)(6)(B)(ii)(I) of the Social Security Act by 4.6 percent for FYs 2018 through 2026.

Extension of the blended payment rate for LTCH site neutral payment rate cases

The blended payment rate for LTCH site neutral payment rate cases is determined by the LTCH PPS Pricer according to the Federal PPS blend indicator variable in the PSF (data element 18, file position 75) so that providers with a value of '6' or '7' are paid a blend of 50 percent of the LTCH standard Federal payment rate payment and 50 percent of the site neutral payment rate payment, while providers with a value of '8' in the Federal PPS blend indicator variable in the PSF are paid 100 percent of the site neutral payment rate payment.

To implement the extension of the blended payment rate provided by Section 51005(a) of the Bipartisan Budget Act of 2018, CMS is revising the description of the Federal PPS blend indicator variable in the PSF for a value of '7' to indicate 50 percent of the site neutral payment rate and 50 percent of the LTCH standard Federal payment rate effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018, or FY 2019 (that is, blend years two through four).

In order to ensure site neutral payment rate for discharges in cost reporting periods beginning in FY 2018 (beginning on or after October 1, 2017, and before October 1, 2018), MACs will update the Federal PPS blend Indicator variable as follows:

6 – Blend year one (represents 50 percent site neutral payment and 50 percent standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2016 (on or after 10/01/2015 through 09/30/16)

7 – Blend years two through four (represents 50 percent site neutral payment and 50 percent standard payment effective for all LTCH providers with cost reporting periods beginning in FY 2017, FY 2018, or FY 2019

8 – Transition blend no longer applies with cost reporting periods beginning in FY 2020 (on or after 10/01/2019)

Therefore, MACs will ensure that the Federal PPS blend indicator variable in the PSF is updated to a value of '7' for any providers with a cost reporting period beginning on or after October 1, 2017, and as such currently have a value of '8' in the Federal PPS blend Indicator variable in the PSF with an effective date of the fiscal year begin date for the cost reporting period.

Adjustment to the LTCH site neutral payment rate cases

As provided by the Social Security Act (§1886(m)(6)(B)), the site neutral payment rate is the lesser of 100 percent of the estimated cost of the case or the "IPPS comparable amount." Section 51005 (b) of the Bipartisan Budget Act of 2018 adjusts the "IPPS comparable payment" component under the site neutral payment rate at §1886(m)(6)(B)(ii)(I) of the Social Security Act (described in Section 412.522(c)(1)(i)) (see *https://www.ecfr.gov/cgi-bin/text-idx?SID=4d2d4d21664431bde481aff4210219ec&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1522*) in each of FYs 2018 through 2026. Specifically, Section 51005(b) reduces the "IPPS comparable amount" component of the site neutral payment rate by 4.6 percent. (CMS notes this 4.6 percent reduction applies to any applicable outlier payments under §412.522(c)(1)(i), as well, and is applied after the application of the site neutral payment rate high cost outlier budget neutrality factor under Section 412.522(c)(2)(i).)

In order to implement this adjustment, Pricer logic has been updated to reflect this reduction to the "IPPS comparable amount" component of the site neutral payment rate for discharges occurring in FY 2018.

Additional information

The official instruction, CR 10547, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4046CP.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
May 14, 2018	Initial article released.

MLN Matters® Number: MM10547
Related CR Release Date: May 10, 2018
Related CR Transmittal Number: R4046CP
Related Change Request (CR) Number: 10547
Effective Date: October 1, 2017
Implementation April 2, 2018

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

Provider type affected

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

Provider action needed

Change request (CR) 10642 informs MACs about the changes in the July 2018 quarterly update to the clinical laboratory fee schedule (CLFS). Make sure that your billing staffs are aware of these changes.

Background

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

Access to data file

Under normal circumstances, CMS will make the updated CLFS data file available to MACs approximately six weeks prior to the beginning of each quarter. For example, the updated file will typically be made available for download and testing on or before approximately May 15 for the July 1 release. Internet access to the quarterly CLFS data file will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*.

Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the internet to retrieve the quarterly CLFS. It will be available in multiple formats: Excel®, text, and comma delimited.

Pricing information

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

New codes

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

The following new codes are effective April 1, 2018:

- 0035U TOS 5; short descriptor—Neuro csf prion prtn qual; long descriptor—Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative
- 0036U TOS 5; short descriptor—Xome tum & nml spec seq alys; long descriptor—Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses
- 0037U TOS 5; short descriptor—Trgt gen seq dna 324 genes; long descriptor—Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
- 0038U TOS 5; short descriptor—Vitamin d srm microsamp quan; long descriptor—Vitamin D, 25 hydroxy D2 and D3, by LC-MS/MS, serum microsample, quantitative
- 0039U TOS 5; short descriptor—Dna antb 2strand hi avidity; long descriptor—Deoxyribonucleic acid (DNA) antibody, double stranded, high avidity
- 0040U TOS 5; short descriptor—Bcr/abl1 gene major bp quan; long descriptor—BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative
- 0041U TOS 5; short descriptor—B brgdrferi antb 5 prtn igm; long descriptor—Borrelia burgdorferi, antibody detection of 5 recombinant protein groups, by immunoblot, IgM
- 0042U TOS 5; short descriptor—B brgdrferi antb 12 prtn igg; long descriptor—Borrelia burgdorferi, antibody detection of 12 recombinant protein groups, by immunoblot, IgG

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- 0043U TOS 5; short descriptor—Tbrf b grp antb 4 prtn igm; long descriptor—Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgM
- 0044U TOS 5; short descriptor—Tbrf b grp antb 4 prtn igg; long descriptor—Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgG0024U Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy, quantitative
- 0012M TOS 5; short descriptor—Onc mrna 5 gen rsk urthl ca; long descriptor—Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and XCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma
- 0013M TOS 5; short descriptor—Onc mrna 5 gen recr urthl ca; long descriptor—Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma

The following new code is effective January 1, 2018:

- 0011M TOS 5; short descriptor—Onc prst8 ca mrna 12 gen alg; long descriptor—Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk

Notes

- In instances where Medicare-covered CLFS procedure codes do not yet appear on the quarterly CLFS file or the quarterly integrated outpatient code editor (I/OCE) update, MACs will locally price the codes until they appear on the CLFS file and/or, for Part A claims, the I/OCE.
- MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust claims that you bring to their attention.

Additional information

The official instruction, CR 10642, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4045CP.pdf*.

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

Document history

Date of change	Description
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MLN Matters® Number: MM10642
Related CR Release Date: May 11, 2018
Related CR Transmittal Number: R4045CP
Related Change Request (CR) Number: 10642
Effective Date: July 1, 2018
Implementation July 2, 2018

Where do I find...

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ICD-10 and other coding revisions to national coverage determinations

Provider type affected

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

Provider action needed

Change request (CR) 10622 constitutes a maintenance update of International Classification of Diseases, 10th Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please follow the link below for the NCD spreadsheets included with this CR: *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10622.zip*.

Background

Previous NCD coding changes appear in ICD-10 quarterly updates that are available at *https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs, will be included in subsequent quarterly releases as needed.

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

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

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

CR 10622 makes coding and clarifying adjustments to the following NCDs:

- NCD 110.18 Aprepitant
- NCD 150.3 Bone mineral density studies
- NCD 190.11 Prothrombin time/international normalized ratio (PT/INR)
- NCD 220.6.16 Positron emission tomography (PET) for infection/inflammation
- NCD 220.6.17 PET for solid tumors
- NCD 220.13 Percutaneous image-guided breast biopsy

When denying claims associated with the attached NCDs, except where otherwise indicated. A/B MACs will use:

- Group code PR (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed advance beneficiary notice (ABN) is on file).
- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). For modifier GZ, use CARC 50 and Medicare summary notice (MSN) 8.81 per instructions in CR 7228/TR 2148.

Additional information

The official instruction, CR 10622, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2076OTN.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
May 9, 2018	Initial article released.

MLN Matters® Number: MM10622
Related CR Release Date: May 4, 2018
Related CR Transmittal Number: R2076OTN
Related Change Request (CR) Number: 10622
Effective Date: October 1, 2018
Implementation October 1, 2018

July 2018 update of drug and biological code changes

***Note**: This article was revised May 14, 2018, to reflect a revised change request (CR), issued May 11. In the article, a sentence is added to show that Part B payment for Q9995 includes the clotting factor furnishing fee. Also, 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 April 2018 Medicare A Connection, page 18.*

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

CR 10624 informs MACs of updated drug/biological Healthcare Common Procedure Coding System (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. Part B payment for HCPCS code Q9995 will include the clotting factor furnishing fee. 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 data base (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/R4048CP.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
May 14, 2018	This article was revised to reflect a revised CR issued May 11. In the article, a sentence is added to show that Part B payment for Q9995 includes the clotting factor furnishing fee. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.
April 20, 2018	Initial article released.

MLN Matters® Number: MM10624 *Revised*
Related CR Release Date: May 11, 2018
Related CR Transmittal Number: R4048CP
Related Change Request (CR) Number: 10624
Effective Date: July 1, 2018
Implementation July 2, 2018

Supervised exercise therapy for symptomatic peripheral artery disease

***Note**: The article was revised May 14, 2018, to reflect a revised change request (CR) issued May 11. The CR was revised to remove place of service code edit requirements. The article was revised accordingly. Also, in the article, the CR release date, transmittal numbers and the web address of the CR are revised. The article was revised May 15, 2018, to clarify that one of the requirements of the SET program is it must be conducted in a hospital outpatient setting or in a physician's office. All other information remains the same. This information was originally published in the April 2018 Medicare A Connection, pages 19-21.*

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

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

Background

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

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

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

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Be conducted in a hospital outpatient setting or a physician's office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD

- Be under the direct supervision of a physician (as defined in Section 1861(r)(1)) of the Social Security Act (the Act), physician assistant, or nurse practitioner/ 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

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

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

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

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 percent 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).

Additional information

The official instruction, CR 10295, was issued to your MAC via two transmittals. The first updates the *Medicare*

See **PAD**, page 35

PAD

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Claims Processing Manual and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4049CP.pdf*. The second updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R207NCD.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
May 15, 2018	The article was revised to clarify that one of the requirements of the SET program is it must be conducted in a hospital outpatient setting or in a physician's office. All other information remains the same.
May 14, 2018	The article was revised to reflect a revised CR issued May 11. The CR was revised to remove place of service code edit requirements. The article was revised accordingly. Also, in the article, the CR release date, transmittal numbers and the Web address of the CR are revised. All other information remains the same.
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.
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: May 11, 2018
Related CR Transmittal Number: R207NCD and R4049CP
Related Change Request (CR) Number: 10295
Effective Date: May 25, 2017
Implementation Date: July 2, 2018

Medicare Learning Network®

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

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: Medicare Speaks 2018 Orlando

Date: Tuesday-Wednesday, June 19-20
Time: 8:00 a.m.-4:30 p.m.
Type of Event: Face-to-face

https://medicare.fcso.com/medicare_speaks/0404327.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 April 26, 2018

MLN Connects® for April 26, 2018

View this edition as a PDF

News & Announcements

- CMS Changes Name of the EHR Incentive Programs and Advancing Care Information to "Promoting Interoperability"
- Protect Medicare and Medicaid: Report Fraud, Waste, and Abuse
- Hospital Inpatient Quality Reporting Program: Submission Deadline May 15
- IRF, LTCH, and SNF Quality Reporting Programs: Submission Deadline May 15
- Open Payments Review and Dispute Data by May 15
- MACRA Funding Opportunity: Deadline Extended to May 30
- STD Awareness Month: Talk, Test, Treat

Provider Compliance

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

Upcoming Events

- Medicare Cost Report e-Filing System Webcast – May 1
- CMS Quality Measures: How They Are Used and How You Can Be Involved Webinar – May 2
- Quality Payment Program: Answering Your Frequently Asked Questions Call – May 16
- Settlement Conference Facilitation Expansion Call – May 22

Medicare Learning Network Publications & Multimedia

- Quarterly HCPCS Drug/Biological Code Changes: July 2018 Update MLN Matters Article — New

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MLN Connects® for May 3, 2018

MLN Connects® for May 3, 2018

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News & Announcements

- New Medicare Cards: You Can Use MBIs Right Away
- New Strategy to Fuel Data-driven Patient Care, Transparency
- CMS Encourages Eligible Suppliers to Participate in Expanded Medicare Diabetes Prevention Program Model
- Patients Over Paperwork April Newsletter
- Hospital Quality Reporting Center Spring 2018 Newsletter
- Administrative Simplification: Transactions
- Can't Find An Answer To Your Question?
- Hand Hygiene Day is May 5

Provider Compliance

- Provider Compliance Tips for Ordering Lower Limb Orthoses

Upcoming Events

- Quality Payment Program: Participation Criteria for Year 2 Webinar — May 9
- eCQI Resource Center Demonstration and Annual Update Webinar — May 10
- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Settlement Conference Facilitation Expansion Call — May 22
- Comparative Billing Report on Critical Care Services Webinar — June 6

Medicare Learning Network Publications & Multimedia

- New Physician Specialty Code for Medical Genetics and Genomics MLN Matters® Article — New
- Processing Instructions to Update the Identification Code Qualifier Being Used in the NM108 Data Element MLN Matters® Article — New
- Revisions to the Telehealth Billing Requirements for Distant Site Services MLN Matters® Article — New

See **Connects®**, page 38

MLN Connects® for May 10, 2018

MLN Connects® for May 10, 2018
View this edition as a PDF

News & Announcements

- First CMS Rural Health Strategy
- Direct Provider Contracting RFI — Submit Comments by May 25
- Provider Documentation Manual: Home Use of Oxygen — Submit Comments on Draft by May 31
- Hospital Compare Preview Reports Available through June 2
- eCQM Annual Update
- Hospital Quality Reporting: 2019 QRDA I Implementation Guide, Schematron, and Sample Files
- 2018 Measure Development Plan Annual Report
- National Women's Health Week Kicks off on Mother's Day

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- Quality Payment Program: Answering Your Frequently Asked Questions Call — May 16
- Managing Older Adults with Substance Use Disorders Webinar — May 16
- FY 2019 IPPS Proposed Rule: eCQM Reporting Webinar — May 16
- Settlement Conference Facilitation Expansion Call — May 22

- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6

Medicare Learning Network Publications & Multimedia

- Inexpensive or Routinely Purchased DME Payment Classification for SGD and Accessories MLN Matters Article — New
- Medicare Cost Report E-Filing MLN Matters Article — New
- MCReF System Webcast: Audio Recording and Transcript — New

CONNECTS

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- Enhancements to Processing of Hospice Routine Home Care Payments MLN Matters Article — New
- Comprehensive ESRD Care Model Telehealth - Implementation MLN Matters Article — New
- Removal of KH Modifier from Capped Rental Items MLN Matters Article — New
- Acute Care Hospital IPPS Booklet — Revised

MLN Connects® for May 17, 2018

MLN Connects® for May 17, 2018

View this edition as a PDF

News & Announcements

- New Medicare Card: MBI Look-up Tool Clarification and RRB Mailing
- Enhanced "Drug Dashboards" to Increase Transparency on Drug Prices
- CMS Safeguards Patient Access to Certain Medical Equipment and Services in Rural and Other Non-contiguous Communities
- Quality Payment Program: Check 2018 MIPS Clinician Eligibility at the Group Level
- Medicare Diabetes Prevention Program Resources
- Hospital Outpatient Quality Reporting Spring 2018 Newsletter
- Talk to Your Patients about Mental Health

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Upcoming Events

- Settlement Conference Facilitation Expansion Call — May 22
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6

Medicare Learning Network Publications & Multimedia

- ICD-10 and Other Coding Revisions to National Coverage Determinations MLN Matters Article — New
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters Article — New
- Updates to Publication 100-04 to Replace RARC MA61 with N382 MLN Matters Article — New

- IPPS and LTCH PPS Extensions per the ACCESS Act MLN Matters Article — New
- Supervised Exercise Therapy for Symptomatic PAD MLN Matters Article — Revised
- Quarterly HCPCS Drug/Biological Code Changes – July 2018 Update MLN Matters Article — Revised
- Medicare Preventive Services National Educational Products — Revised
- Power Mobility Devices Booklet — Reminder
- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Reminder
- Medicare Advance Written Notices of Noncoverage Booklet — Reminder
- Long-Term Care Hospital Prospective Payment System Booklet — Reminder
- Medicare Disproportionate Share Hospital Fact Sheet — Reminder
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Reminder

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp.* This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

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
Mechanicsburg, PA 17055-1849

Redetermination
Florida:
Medicare Part A Redetermination/Appeals
P. O. Box 3409
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