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A Newsletter for MAC Jurisdiction N Providers

**June 2018** 



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## **Update of Publication 100-04, Chapter 18 - preventive and screening services, and Chapter 35 - IDTF**

#### Provider type affected

This *MLN Matters*® article is intended for independent diagnostic testing laboratories (IDTFs) billing Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

#### What you need to know

Change request (CR) 10735 updates *Medicare Claims Processing Manual*, Chapter 18 - *Preventive and Screening Services* and Chapter 35 - *Independent Diagnostic Testing Facility (IDTF)* to include requirements and payment policies for screening mammography services furnished by IDTFs. CR 10735 does not convey any policy changes. Instead, it just documents current policy in the *Medicare Claims Processing Manual*.

#### **Background**

If an IDTF furnishes any type of mammography service (screening or diagnostic), it must have a Food and Drug Administration (FDA) certification to perform such

services. However, an entity that only performs diagnostic mammography services should not be enrolled as an IDTF.

Screening mammographies (including those that are self-referred) are payable by Medicare when performed in and by an IDTF entity.

#### Additional information

The official instruction, CR 10735, issued to your MAC regarding this change is available at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4071CP.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Guidance/Transmittals/2018Downloads/R4071CP.pdf</a>.

If you have questions, your MACs may have more information. Find their website at <a href="https://go.cms.gov/MAC-website-list">https://go.cms.gov/MAC-website-list</a>.

#### **Document history**

Date of change	Description
June 8, 2018	Initial article released.

See IDTF, page 34





WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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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.

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#### **Processing Issue**

## System edit has been turned off for certain EKG services

#### Issue

A system edit has been turned off that was rejecting and denying claims for certain electrocardiographic (EKG) services.

#### Resolution

Medicare administrative contractors (MACs) will reprocess impacted claims.

#### Status/date resolved

Open

#### **Provider action**

None; if you have any questions please contact your MAC provider contact center.

## Current processing issues

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



#### **General Information**

### New Medicare beneficiary identifier (MBI) get it, use it

#### Provider type affected

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

#### Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is mailing the new Medicare cards with the MBI in phases by *geographic location*. Here are three ways you and your office staff can get MBIs:

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare card when they come for care. If they haven't received a new card at the completion of their geographic wave, refer them to 1-800-Medicare (1-800-633-4227).

2. Use the MAC's secure MBI look-up tool

Once the new Medicare card with the MBI has been mailed to your patient, you can look up MBIs for your Medicare patients when they don't or can't give them. *Sign up* for the portal to use the tool. You can use this tool even after the end of the transition period – it doesn't end December 31, 2019.

3. Check the remittance advice

Starting in October 2018 through the end of the transition period, we'll also return the MBI on every remittance advice when you submit claims with valid and active health insurance claim numbers (HICNs).

You can start using the MBIs even if the other health

care providers and hospitals who also treat your patients haven't. When the transition period ends on December 31, 2019, you must use the MBI for most transactions.

#### **Background**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare beneficiary identifier, or MBI, is replacing the SSN-based HICN. The new MBI is noticeably different than the HICN. Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.



The Railroad Retirement Board (RRB) is also mailing new Medicare cards with the MBI. The RRB logo will be in the upper left corner and "Railroad Retirement Board" at the bottom, but you can't tell from looking at the MBI if your patients are eligible for Medicare because they're railroad retirees. You'll be able to identify them by the RRB logo on their card, and we'll return a Railroad retirement Medicare beneficiary message on the fee-for-service (FFS) MBI eligibility transaction response.

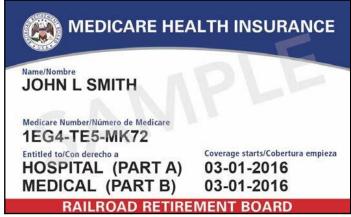
See MBI, page 4



#### MBI

from page 3

#### **RRB** issued Medicare card



Use the MBI the same way you use the HICN today. Put the MBI in the same field where you've always put the HICN. This also applies to reporting informational only and no-pay claims. Don't use hyphens or spaces with the MBI to avoid rejection of your claim. The MBI will replace the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. Until December 31, 2019, you can use either the HICN or the MBI in the same field where you've always put the HICN. After that the remittance advice will tell you if we rejected claims because the MBI wasn't used. It will include claim adjustment reason code (CARC) 16. "Claim/service lacks information or has submission/billing error(s)." along with remittance advice remark code (RARC) N382 "Missing/ incomplete/invalid patient identifier".

The beneficiary or their authorized representative can request an MBI change. CMS can also initiate a change to an MBI. An example is if the MBI is compromised. There are different scenarios for using the old or new MBIs:

FFS claims submissions with:

- Dates of service before the MBI change date use the old or new MBI.
- Span-date claims with a "From Date" before the MBI change date – use the old or new MBI.
- Dates of service that are entirely on or after the effective date of the MBI change – use the new MBI.

FFS eligibility transactions when the:

- Inquiry uses new MBI we'll return all eligibility data.
- Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI – we'll return all eligibility data. We'll also return the old MBI termination date.
- Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we'll return an error code (AAA 72) of "invalid member ID."

When the MBI changes, we ask the beneficiary to share the new MBI with you. You can also get the MBI from your MACs secure MBI lookup tool.

## Protect the MBI as personally identifiable information (PII); it is confidential like the HICN.

Submit all HICN-based claims by the end of the transition period, December 31, 2019. On January 1, 2020, even for dates of services before this date, you must use MBIs for all transactions; there are a few exceptions when you can use either the HICN or MBI:

- Appeals You can use either the HICN or MBI for claim appeals and related forms.
- Claim status query You can use HICNs or MBIs to check the status of a claim (276transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.
- Span-date claims You can use the HICN or the MBI for 11x-inpatient hospital, 32x-home health (home health claims and request for anticipated payments [RAPs]) and 41x-religious non-medical health care institution claims if the "From Date" is before the end of the transition period (December 31, 2019). If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, but stops getting those services after December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019. Since you submit home health claims for a 60-day payment episode, you can send in the episode's RAP with either the HICN or the MBI, but after the transition period ends on December 31, 2019, you have to use the MBI when you send in the final claim that goes with it.

The MBI does not change Medicare benefits. Medicare beneficiaries may start using their new Medicare cards and MBIs as soon as they get them. Use MBIs as soon as your patients share them. The new cards are effective the date beneficiaries are eligible for Medicare.

Medicare advantage and prescription drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

#### Additional information

If you have questions, your MACs may have more information. Find their website at <a href="https://go.cms.gov/MAC-website-list">https://go.cms.gov/MAC-website-list</a>.

The MBI format specifications, which provide more details on the construct of the MBI, are available at <a href="https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf">https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf</a>.

A fact sheet discussing the transition to the MBI and the new cards is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TransitiontoNewMedicareNumbersandCards-909365.pdf.

See MBI, page 5

#### Provider enrollment – unlicensed residents

#### Provider type affected

This MLN Matters® article is intended for unlicensed

resident physicians who need to enroll in the Medicare program through Medicare administrative contractors (MACs). The article is also intended for the providers for whom these residents will practice.

#### What you need to know

Effective as soon as possible but no later than June 17, 2018, MACs will process CMS Form-855O provider enrollment applications submitted for

unlicensed residents if the application submission includes either, 1) a residency contract signed and dated by both an official of the institution and the resident physician or, 2) a letter, on institution letterhead, confirming the applicants status as a resident physician signed and dated by an official of the institution and containing at a minimum the name of the applicant.

MACs shall approve the enrollment if the applicant passes all screening requirements and provides proof of residency as described above.



#### **Additional information**

If you have questions, your MACs may have more

information. Find their website at https://go.cms.gov/MAC-website-list.

#### **Document history**

Date of change	Description
June 8, 2018	Initial article released.

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Related CR Release Date:

June 8, 2018 Related CR Transmittal

Number: N/A

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Effective Date: N/A Implementation: N/A

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#### MBI

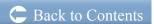
from page 4

#### **Document history**

Date of change	Description
June 21, 2018	The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim. All other information remains the same.
May 25, 2018	Initial article released.

MLN Matters® Number: SE18006 Revised
Related CR Release Date: June 21, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A

Effective Date: N/A Implementation N/A



## Provider/supplier reporting of adverse legal actions

#### Provider type affected

This *MLN Matters*® article is intended to update the Medicare provider and supplier community on what final adverse action(s) need to be timely reported to the Centers for Medicare & Medicaid Services (CMS).

#### Who should report final adverse action(s)

- Medicare providers or suppliers with new or unreported final adverse action(s)
- Those individuals listed on an application as having managing control or an ownership interest

## What final adverse action(s) should be reported

Historically, CMS deemed *Medicare Payment Suspensions* and *CMS-Imposed Medicare Revocations* to be reportable final adverse actions. In an effort to reduce provider and supplier burden, CMS **no longer** requires *Medicare Payment Suspensions* and *CMS-Imposed Medicare Revocations* to be reported.

The updated list of reportable final adverse actions is as follows:

- Felony and misdemeanor conviction(s) within 10 years
- Current or past suspension(s)/revocation(s) of a medical license
- Current or past suspension(s)/revocation(s) of an accreditation
- Current or past suspension(s) or exclusion(s) imposed by the U.S. Department of Health and Human Service's Office of Inspector General (OIG)
- Current or past debarment(s) from participation in any federal executive branch procurement or nonprocurement program
- Medicaid exclusion(s), revocation(s) or termination(s) of any billing number
- Any other current or past federal sanction(s)

Please note that all final adverse actions should be reported, regardless of whether any of the records have been expunged or are pending appeal.

#### When final adverse action(s) be reported

Providers and suppliers shall timely report all new or unreported final adverse actions on any applications submitted to CMS. Final adverse actions must be reported by providers and suppliers within time frames specified in 42 CFR § 424.516.

## How final adverse action(s) should be reported

Providers and suppliers shall disclose reportable final adverse legal actions on any CMS-855 or CMS-20134 application submitted to CMS. As it applies, the sections of the application(s) that providers must complete are:

- Section 3
- Section 5B
- Section 6B
- Section 7

If a final adverse action is disclosed on a CMS-855 application, a provider/supplier must attach all applicable documentation related to the adverse action.

Please note that documentation, concerning the final adverse action, must be furnished regardless of whether the adverse action occurred in a state different from that in which the provider/supplier seeks enrollment or is enrolled.

It is important that you comply with these reporting requirements. Failure to do so could result in the revocation of your Medicare billing privileges.

#### Additional information

The official instruction, CR 10558, issued to your MAC is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R797PI.pdf.

If you have questions, your MACs may have more information. Find their website at <a href="https://go.cms.gov/MAC-website-list">https://go.cms.gov/MAC-website-list</a>.

#### **Document history**

Date of change	Description
June 7, 2018	Initial article released.

MLN Matters® Number: MM10558
Related CR Release Date: June 1, 2018
Related CR Transmittal Number: R797PI
Related Change Request (CR) Number: 10558

Effective Date: April 30, 2018 Implementation April 30, 2018

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 <a href="https://medicare.fcso.com/Landing/139800">https://medicare.fcso.com/Landing/139800</a>. 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 <a href="https://medicare.fcso.com/Header/137525.asp">https://medicare.fcso.com/Header/137525.asp</a>, 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 <a href="https://medicare.fcso.com/coverage\_find\_lcds\_and\_ncds/lcd\_search.asp">https://medicare.fcso.com/coverage\_find\_lcds\_and\_ncds/lcd\_search.asp</a>, helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your internet connection, the LCD search process can be completed in less than 10 seconds.

### **Advance beneficiary notice**

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

**Note**: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

#### Search capability simplifies LCD lookup

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

Providers can simply enter a procedure code, keyword, or ICD-10 code into the website search bar and search "LCDs only" to find the matching results. This search function replaces the multiple steps previously required by other methods, and lets providers locate the corresponding LCDs by using First Coast's own LCD data.

Click here for more information.



#### **Retired LCDs**

### Circulating tumor cell testing – retired Part A and Part B LCD

## LCD ID number: L33279 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for circulating tumor cell testing, it was determined that the LCD is no longer required and, therefore, is being retired.

#### Effective date

The retirement of this LCD is effective for services rendered **on or after May 25, 2018**. LCDs are available through the CMS Medicare coverage database at <a href="https://www.cms.gov/medicare-coverage-database/overview-and-database/overview-

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*.



## **Lower extremity revascularization – retired Part A and Part B LCD**

## LCD ID number: DL37404 (Florida, Puerto Rico/U.S. Virgin Islands)

The draft local coverage determination (LCD) for lower extremity revascularization is being retired. The draft

LCD was posted for the 45-day comment May 18, 2017 to July 6, 2017. The contractor would like to thank those who submitted comments; however, the contractor has determined that the proposed LCD will be rewritten. Therefore, this proposed LCD is being retired.

#### **Revisions to LCDs**

# Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications — revision to the Part A and Part B LCD

## LCD ID number: L33270 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an external correspondence and multiple reconsideration requests, the local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was revised to add the Food and Drug Administration (FDA) approved indication "prevention of skeletal-related events in patients with multiple myeloma" to the "FDA indication for XGEVA®" and "Documentation Requirements" sections of the LCD. Also, ICD-10-CM diagnosis codes C90.00, C90.01, C90.02 and M84.50XA - M84.58XS were added to the "ICD-10" Codes that Support Medical Necessity" section of the LCD under "Group 4 Codes" for Healthcare Common Procedure Coding System (HCPCS) code J0897 (Xgeva®) and the "Limitations" section of the LCD was updated to include a statement that "Effective for dates of service on or after 01/04/2018, the FDA has approved denosumab (Xgeva®) for the treatment of skeletal-related events in patients with multiple myeloma." In addition, the statement indicating the requirement of documentation of serum creatinine level prior to the administration of Prolia® was removed from the

"Documentation Requirements" section of the LCD under the subtitle "Prolia All Patients." Finally, the "Sources of Information" section of the LCD was also updated.

#### Effective date

The revision related to the addition of the ICD-10-CM codes, the FDA indication for Xgeva® and sources of information is effective for claims processed on or after June 21, 2018, for dates of service on or after January 4, 2018.

The revision related to the removal of the statement indicating the requirement of documentation of serum creatinine level prior to the administration of Prolia® and the addition of sources of information is effective for services rendered **on or after June 21, 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.

### Fulvestrant (Faslodex) – revision to the Part A and Part B LCD

## LCD ID number: L33998 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request for fulvestrant (Faslodex), the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD was revised to add the indications for uterine neoplasms, endometrial carcinoma, and uterine leiomyosarcoma. In addition, ICD-10-CM diagnosis codes C54.0-C54.9 and C55 were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) code J9395. Also, the "Sources of Information and Basis for Decision" section of the LCD was updated.

#### **Effective date**

This LCD revision is effective for claims processed on or after June 14, 2018, for services rendered on or after August 1, 2016. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <a href="https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx">https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx</a>.

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*.

## Gemcitabine (Gemzar) — revision to the Part A and Part B LCD

## LCD ID number: L33726 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request for gemcitabine (Gemzar), the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD was revised to add the indication for bone cancer - osteosarcoma. In addition, ICD-10-CM diagnosis codes C40.01, C40.02, C40.11, C40.12, C40.21, C40.22, C40.31, C40.32, C40.81, C40.82, C41.0, C41.1, C41.2, C41.3, and C41.4 were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) code J9201. Also, the "Sources of Information" section of the LCD was updated.

#### **Effective date**

This LCD revision is effective for services rendered **on or after June 14, 2018.** LCDs are available through the CMS Medicare coverage database at <a href="https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx">https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx</a>.

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*.

## Hyperbaric oxygen (HBO) therapy — revision to the Part A and Part B LCD

## LCD ID number: L36504 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an internal correspondence, the local coverage determination (LCD) for hyperbaric oxygen (HBO) therapy was revised in the "Coverage Indications, Limitations, and/ or Medical Necessity" section of the LCD to remove the requirement for direct supervision of a maximum of five (5) minute response time to the chamber, as direct physician supervision is not defined in terms of time or distance by the Centers for Medicare & Medicaid Services (CMS). In addition, "bowel" was removed from "Specific Conditions" section of the LCD under number nine, as it is not a covered diagnosis code per the National Coverage Determination (NCD) for Hyperbaric Oxygen Therapy (NCD 20.29).

#### Effective date

This LCD revision is effective for services rendered **on or after May 31, 2018.** LCDs are available through the CMS Medicare coverage database at <a href="https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx">https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx</a>.

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*.

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

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

Based on an annual review of the local coverage determination (LCD) for molecular pathology procedures for human leukocyte antigen (HLA) typing, it was determined that some of the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" and "Utilization Guidelines" sections of the LCD do not represent direct quotations from some of 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 22, 2018.** LCDs are available through the CMS Medicare coverage database at <a href="https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx">https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx</a>.



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

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

## Nerve conduction studies and electromyography — revision to the Part A and Part B LCD

## LCD ID number: L34859 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the nerve conduction studies and electromyography local coverage determination (LCD), it was determined that the italicized language in the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, this LCD is being revised to assure consistency with the CMS manual language. In addition, the "CPT®/HCPCS Codes:" section of the LCD was updated to combine the "Group 1 Codes:" and "Group 2 Codes" to align with the "Group Codes" in the "ICD-10 Codes that Support Medical Necessity" section of the LCD. The effective date of this revision is based on process date.

#### Effective date

The LCD revision related to assuring consistency with the CMS manual language is effective for services rendered on or after May 31, 2018.

The LCD revision related to aligning the "Group Codes" is



effective for claims processed on or after May 31, 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*.

## Psychiatric partial hospitalization program — revision to the Part A LCD

## LCD ID number: L33972 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the psychiatric partial hospitalization program 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 does not represent direct quotation from the Centers for Medicare & Medicaid Services (CMS) sources. Therefore, this LCD is being revised to assure consistency with the CMS manual language.

#### Effective date

The LCD revision is effective for services rendered **on or after May 31, 2018.** LCDs are available through the CMS Medicare coverage database at <a href="https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx">https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx</a>.

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*.

## Scanning computerized ophthalmic diagnostic imaging (SCODI) — revision to the Part A and Part B LCD

## LCD ID number: L33751 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the scanning computerized ophthalmic diagnostic imaging (SCODI) LCD was revised in the "Bibliography" section of the LCD to include multiple published sources. The content of the LCD has not been changed in response to the reconsideration request.

#### **Effective date**

The LCD revision is effective for services rendered **on or after May 31, 2018.** LCDs are available through the CMS Medicare coverage database at <a href="https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx">https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx</a>.

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*.

#### **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.

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

**Note**: This article was revised May 25, 2018, to reflect the revised change request (CR) 10474 issued May 24 to correct the code description for ICD-10-CM D68.32. In the article, the code description is corrected and the CR release date, transmittal number and the web address for accessing the CR are revised. All other information remains the same. This information was previously published in the March 2018 Medicare A Connection, page 20.

#### Provider type affected

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

#### What you need to know

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

#### **Background**

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

Effective July 1, 2018, code D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants) is **terminated**. Therefore, providers that include diagnosis code D68.32 on inpatient claims with discharge dates after July 1, 2018, will not receive the add-on payment.

#### Additional information

The official instruction, CR 10474, issued to your MAC regarding this change is available at <a href="https://">https://</a>

www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4062CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <a href="https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html">https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html</a>.

#### **Document history**

Date of change	Description
May 25, 2018	This article was revised to reflect the revised CR 10474 issued May 24 to correct the code description for ICD-10-CM D68.32. In the article, the code description is corrected and the CR release date, transmittal number and the web address for accessing the CR are revised. All other information remains the same.
March 2, 2018	This article was revised to reflect the revised CR 10474 issued March 1. In the article, the CR release date, transmittal number and the web address for accessing the CR are revised. All other information remains the same.
February 9, 2018	Initial article released.

MLN Matters® Number: MM10474 Revised
Related CR Release Date: May 24, 2018
Related CR Transmittal Number: R4062CP
Related Change Request (CR) Number: 10474

Effective Date: July 1, 2018 Implementation July 2, 2018

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#### Calculate the possibilites ...



Whether you're estimating the amount of a Medicare payment, the length of an ESRD coordinating period, or the deadlines for sending an appeals request or responding to an additional development request, try the easy way to calculate the possibilities. Find everything you need to "do it yourself" in our Tool center.

## Avoid issues completing the PWK fax/mail coversheet

First Coast Service Options' (First Coast's) claims department encourages you to avoid submitting invalid or unnecessary PWK (5010 paperwork segment) fax/mail coversheets. If a coversheet is received containing inaccurate, incomplete, or invalid information, the coversheet will be either faxed or mailed back to the originating source, but without the documentation. Coversheets returned in this manner should not be resent; instead, the provider should await an additional documentation request (ADR) before submitting the documentation again to First Coast.

#### **PWK** issues

In some cases, the coversheets and additional documentation are not able to be appropriately attached to a claim due to several reasons. The following list has been developed to assist you in avoiding these situations.

- PWK coversheet is received, completed accurately with documentation, but the claim was submitted without the indicators in the PWK loop.
  - This will not allow us to assign the documentation in the system to the appropriate claim. If the claim requires documentation, an ADR letter will be sent and providers will need to respond to the letter.
- PWK coversheet is received with the related documentation attached and a copy of our additional documentation request (ADR) letter. Again, the PWK loop indicators are not on the claim.
  - There are two issues here: 1) without the PWK loop completed, the claim will not suspend to look for any anticipated documentation. Most importantly 2) the claim has already suspended for additional documentation; therefore, providers only need to respond to the ADR letter with appropriate documentation.
- 3. PWK coversheet is received with a request for an appeal/redetermination in the information box.
  - The PWK process may only be used on initial claim submission. PWK cannot be used to bypass the standard appeals process. Please use the appropriate level of the appeals process if your claim has been denied or you need to make adjustments/corrections. Appeal requests submitted via the PWK fax/mail process will not be acknowledged.
- 4. In all of these instances, since the PWK fax/mail coversheet and/or claim is not being submitted correctly or with the correct information, the supporting documentation submitted to us is not being utilized



to adjudicate the claim. Also, since in most cases this is outside of the standards for PWK, providers affected by these scenarios will not receive a response concerning the outcome or lack thereof.

5. Our internal claims area is being negatively impacted as well as our electronic storage capacity is being overwhelmed by unneeded, unusable documentation. Providers affected by this will more than likely never receive any indication of the negative impacts this is having on their claims.

#### Reminders

Here are some items to verify before faxing or mailing your form:

- Verify you have indicated the ACN (attachment control number [submitted in the PWK06 segment]), DCN (document control number [Part A]), ICN (internal control number [Part B]), the beneficiary's Medicare ID, billing provider's name and NPI (national provider identifier) on the fax/mail coversheet.
- Include an address to mail the coversheet to, in case we are unable to fax it back to the originating number.
- Fax users: ensure to send your PWK fax coversheet and documentation to the appropriate locality fax line. Example: Claims for providers in Puerto Rico should be faxed to the Puerto Rico fax line; claims for Florida providers to the Florida fax line; etc. If a coversheet is received into the incorrect Faxination account, we will be unable to locate the claim.
- Do not send in documentation without the completed fax/mail coversheet.
- Do not use the PWK coversheet for any reason other than the PWK process.
- Do not modify the fax/mail coversheets.



## Remittance advice remark code, claims adjustment reason code, MREP and PC Print update

#### Provider type affected

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

#### Provider action needed

Change request (CR) 10620 updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists and instructs Medicare shared system maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Be sure your staff are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

#### **Background**

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

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that occurs three times per year – around March 1, July 1, and November 1. CMS provides CR 10620 as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare's SSMs have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date

specified in CR 10620, MACs must implement on the date specified on the WPC website available at <a href="http://wpc-edi.com/Reference/">http://wpc-edi.com/Reference/</a>.

A discrepancy between the dates may arise because the WPC website is only updated three times per year and may not match the CMS release schedule. For CR 10620, MACs and SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update referenced in CR 10489.

#### **Additional information**

The official instruction, CR 10620, issued to your MAC regarding this change is available at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4057CP.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4057CP.pdf</a>.

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

#### **Document history**

Date of change	Description
May 18, 2018	Initial article released.

MLN Matters® Number: MM10620 Related CR Release Date: May 18, 2018 Related CR Transmittal Number: R4057CP Related Change Request (CR) Number: 10620

Effective Date: October 1, 2018 Implementation October 1, 2018

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#### 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.





## Claim status category and claim status codes update

#### Provider type affected

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

#### Provider action needed

Change request (CR) 10777 updates, as needed, the claim status and claim status category codes used for the Accredited Standards Committee (ASC) X12 276/277 health care claim status request and response and ASC X12 277 health care claim acknowledgment transactions. Make sure your billing staffs are aware of these updates.

#### **Background**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status and claim status category codes approved by the National Code Maintenance Committee in the ASC X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/ February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The committee allows the industry six months for implementation of newly added or changed codes.

The codes sets are available at <a href="http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/">http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/</a>. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2018 committee meeting shall be posted on these sites on or about July 1, 2018.

The Centers for Medicare & Medicaid Services (CMS) will issue future updates to these codes, as needed. MACs must update their claims systems to ensure that the current version of these codes is used in their claim status responses.

These code changes are used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 10777.

The CMS' Medicare contractors must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and response. These contractors must use valid claim status and claim status category codes when sending ASC X12 277 health care claim status responses. They must also use valid claim status and claim status category codes when sending ASC X12 277 healthcare claim acknowledgments. References in CR 10777 to "277 responses" and "claim status responses" encompass both the ASC X12 277 health care claim status response and the ASC X12 277 healthcare claim acknowledgment transactions.

#### Additional information

The official instruction, CR 10777, issued to your MAC regarding this change is available at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4066CP.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4066CP.pdf</a>.

If you have questions, your MACs may have more information. Find their website at <a href="https://go.cms.gov/MAC-website-list">https://go.cms.gov/MAC-website-list</a>.

#### **Document history**

Date of change	Description
June 1, 2018	Initial article released.

MLN Matters® Number: MM10777 Related CR Release Date: June 1, 2018 Related CR Transmittal Number: R4066CP Related Change Request (CR) Number: 10777

Effective Date: October 1, 2018 Implementation October 1, 2018



## Recent and upcoming improvements in hospice billing and claim processing

#### Provider type affected

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

#### Provider action needed

Hospice billing staff should review this article to understand the recent and upcoming Medicare improvements to hospice billing and claim processing.

#### **Recent improvements**

## **Submitting notices of election via electronic data interchange**

To be covered by the Medicare hospice benefit, a beneficiary must sign an election statement, indicating their choice of hospice care instead of curative treatment. The hospice notifies the Medicare program that a beneficiary's election is on file by submitting a notice of election (NOE). The NOE is submitted like a claim. The NOE processes through Medicare claim systems, which updates beneficiary records and later uses the information to adjudicate hospice claims.

Before January 1, 2018, the hospice could only submit NOEs using paper claim forms or key-entering the NOE information into the MAC's direct data entry (DDE) screens. The hospice industry requested that Medicare implement submission of NOEs via electronic data interchange (EDI). EDI transmission and receipt of NOEs would reduce, and potentially eliminate, problems with NOEs that result from DDE keying errors. Hospices could export data from their electronic medical record or other software system into the EDI format without human intervention.

Effective January 1, 2018, Medicare began to accept NOE and related transaction data using a non-standard implementation of the 837l claim transaction. Medicare published a companion guide for NOE transmissions in the *Downloads* section on the CMS hospice services website at <a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html">https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html</a>.

This companion guide provides hospices and their software vendors instructions for how to complete data elements required by the 837I claim transaction but not required by an NOE. Hospices may voluntarily agree to adopt the companion guide and use it to submit EDI NOEs at any time.

## Correcting election or revocation dates using occurrence code 56

Along with the companion guide, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR)

10064 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3866CP.pdf),

which clarified submission instructions for NOEs and related transactions. The instructions allow hospices to use a new occurrence code 56 when submitting corrections to election or revocation dates.

In the past, if a hospice made an error in the election date on an NOE (type of bill (TOB) 8xA), the hospice had to cancel the incorrect election (using TOB 8xD) and then submit a replacement NOE. This would correct the election date in Medicare systems, but the original NOE receipt date was lost. When the replacement NOE was processed, it often appeared that it was submitted after the five-day timely filing period. This in turn resulted in the need to request an exception to the NOE timely filing requirement. This was an administrative burden.

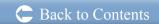
Now, in order to correct an election date, the hospice can simply submit another TOB 8xA, using the correct election date as the from, admission dates and occurrence code 27 dates. The hospice must also submit the original, incorrect election date on the 8xA using occurrence code 56. Medicare systems use this date to find the election record to be corrected, then replaces that election date with the corrected information. The hospice must also indicate the NOE is a correction by adding condition code D0 (zero). If occurrence code 56 and condition code D0 are not both present, the NOE will be returned to the hospice.

In the example below, an incorrect election date of 1/1 is corrected to 1/7:

corrected to 1/1.		
MAP1711 PAGE 01	JM MAC SC/HHH UAT #11001	ACMFA891 05/18/18
<u>SC</u>	INST CLAIM ENTRY	C201823P 09:17:43
HIC xxxxxxxxxx TOB 81	A <u>S/LOC</u> S B0100 <u>OSCAR</u>	SV: UB-FORM
NPI 1xxxxxxxx0 TRANS HOSP	PROV PROCESS NEW H	IIC
PAT.CNTL#:	TAX#/SUB: TA	AXO.CD:
STMT DATES FROM 0107xx		CO LTR
LAST xxx	FIRST xxx MI	DOB xxxxxxxx
ADDR 1 xxx	<u>2</u> xxx	
<u>3</u>	<u>4</u>	CARR:
<u>5</u>	<u>6</u>	LOC:
ZIP xxxxxxxx SEX x MS	ADMIT DATE 0107xx HR TYPE SRC	D HM STAT
COND CODES 01 D0 02	03 04 05 06 07 08	<u>09</u> <u>10</u>
OCC CDS/DATE 01 27 0107x:	x <u>02</u> 56 0101xx <u>03</u> <u>04</u>	<u>05</u>
<u>06</u>	<u>07</u> <u>08</u> <u>09</u>	<u>10</u>
SPAN CODES/DATES 01	02	03
<u>04</u> <u>05</u>	<u>06</u>	07
<u>08</u> <u>09</u>	<u>10</u>	FAC.ZIP
DCN		
Y A L U E C O D E	S - AMOUNIS - ANSI	MSP APP IND
<u>01</u>	<u>02</u>	
<u>04</u>	<u>05</u>	
<u>07</u>	<u>09</u>	
PLEASE ENTER DATA		
PRESS PF3-EXIT PF5	-SCROLL BKWD PF6-SCROLL FWD PF7-F	PREV PF8-NEXT

The hospice can use a similar process to correct a revocation date, if the wrong date was submitted on a notice of termination/revocation (NOTR) using TOB 8xB. The hospice can submit another TOB 8xB, using the correct revocation date as the through date. The hospice must also submit the original, incorrect revocation date on the 8xB using occurrence code 56.

See **HOSPICE**, page 17



#### **HOSPICE**

from page 16

In the example below, the original revocation date of 3/28 is corrected to 3/31:

MAP1711 PAGE 01	JM MAC SC/HHH UAT #11001	ACMFA891 05/18/18
<u>sc</u>	INST CLAIM ENTRY	C201823P 09:28:24
HIC xxxxxxxxxx TOB 81B	S/LOC S B0100 OSCAR	SV: UB-FORM
NPI 1xxxxxxxx0 TRANS HOSP P	ROV PROCESS NEW	HIC
PAT.CNTL#:	TAX#/SUB:	AXO.CD:
STMT DATES FROM 0107xx TO	0331xx DAYS COV N-C	CO LTR
LAST xxx	FIRST xxx MI	DOB xxxxxxx
ADDR 1 xxx	<u>2</u> xxx	
<u>3</u>	4	CARR:
<u>5</u>	<u>6</u>	LOC:
ZIP xxxxxxxxx SEX x MS AD	MIT DATE 0107×× HR TYPE SRO	D HM STAT
COND CODES 01 D0 02 0	<u>3 04 05 06 07 08</u>	<u>09</u> <u>10</u>
OCC CDS/DATE 01 56 0328xx	<u>02</u> <u>03</u> <u>04</u>	<u>05</u>
	07 08 09	10
SPAN CODES/DATES 01	<u>02</u>	<u>03</u>
<u>04</u> <u>05</u>	<u>06</u>	<u>07</u>
<u>08</u>	<u>10</u>	FAC.ZIP
DCN		
<u> </u>		MSP APP IND
<u>01</u> <u>02</u>		
<u>04</u> <u>05</u>	_	
<u>07</u> <u>08</u>	<u>09</u>	
PLEASE ENTER DATA		
PRESS PF3-EXIT PF5-S	CROLL BKWD PF6-SCROLL FWD PF7-	PREV PF8-NEXT

If a revocation date was submitted entirely in error (for instance, the beneficiary actually transferred to another hospice, rather than revoking their hospice benefit), the hospice can remove the revocation date by submitting TOB 8xB with zeroes in the through date. The hospice must submit the original, incorrect revocation date on the NOTR using occurrence code 56 and indicate the NOTR is a correction by adding condition code D0.

Note that these correction processes only apply to election or revocation dates on and after January 1, 2018.

#### **Upcoming improvements**

Over the past two years, Medicare has been planning, developing and testing a redesign of the way hospice elections are displayed in claim processing systems. The redesign ensures that hospice election and revocation date information are separate from benefit period information, so the two types of information can be changed independently.

A new hospice election period will be added to the common working file (CWF) system to carry election-related information. The existing hospice benefit period screens will continue to look the same, but election-related fields on those screens (revocation indicators, NOE receipt dates) will no longer be used. These changes will be implemented July 2, 2018.

MACs will convert all existing hospice benefit periods into the new election period and benefit period format if the revocation date on the benefit period is blank (current elections) or is four years old or less. Older benefit periods will remain in Medicare systems unchanged. All new hospice elections received on or after July 2, 2018, will create periods in the new formats.

This redesign of CWF hospice information will have the following benefits:

 Reduce NOE timely filing exception requests for providers, by ensuring benefit periods can be cancelled without removing the NOE receipt date.

- Allow NOTRs to be submitted at any time, rather than only when a benefit period covering the revocation date has been created by claims.
- Reduce workload for providers when reprocessing periods by automatically removing benefit periods when all claims in the period are cancelled.
- Enable easier implementation of future policy changes by ensuring data in Medicare systems reflect hospice coverage requirements more clearly.

The remainder of this article describes the new design in greater detail and provides guidance for hospices about changes in their submission process.

#### New election period file and screen

Beginning July 2, 2018, when a hospice submits an NOE (TOB 8xA), Medicare systems will create an election period in Medicare systems that is separate from any benefit periods. Hospices will be able to view the election period on new CWF and DDE inquiry screens that look like this:

## ELGA CWF PART A ELIGIBILITY SYSTEM ELGACRO

MM/DD/CCYY HH:MM:SS HOSPICE ELECTION PERIOD PAGE 17 OF XX

IP-REC CN XXXXXXXXXXX NM XXXXXX IT X DB MMDDCCYY SX X INT XXXXX

**HOSPICE** 

ELECTION PERIOD X PERIOD X PERIOD X ELECT DATE MMDDCCYY MMDDCCYY MMDDCCYY MMDDCCYY

RECIPT DATE MMDDCCYY MMDDCCYY MMDDCCYY MMDDCCYY

REVOC DATE MMDDCCYY MMDDCCYY MMDDCCYY MMDDCCYY

**REVOC IND 9 9 9 9** 

The hospice election period only contains identifying information for the beneficiary and the provider, plus key pieces of information each about the election (the election date and the NOE receipt date) and about the revocation (the revocation date and revocation indicator). When an 8xA is processed, the election date and receipt date will be updated on the election period CWF inquiry screen.

The NOE receipt date will be retained on the election period permanently. If a benefit period is cancelled, this will no longer remove the NOE receipt date from Medicare systems. If the election date is changed using the occurrence code 56/condition code D0 process described above, the NOE receipt date will not change. These improvements will reduce the number of NOE timely filing exceptions related to limitations in Medicare systems.

See HOSPICE, page 18



#### HOSPICE

## from page 17 Benefit periods

Unlike the past process, the 8xA will not create a hospice benefit period. Benefit periods will be created by submitting claims. The CWF inquiry screen (ELGH, screen page 09) displaying benefit periods will look the same as it does today. Benefit period information will support claims processing functions only, while the election period carries only the beneficiary's election status.

Hospice providers will no longer need to submit Void/Cancel Notices (TOB 8xD) in order to remove hospice benefit periods. If a hospice needs to cancel all the claims in a benefit period, Medicare systems will remove the hospice benefit period only when all the claims are cancelled. This will reduce the number of submissions required when reprocessing periods due to sequential billing issues or other circumstances. Since the NOE receipt date will remain on the election period when the benefit period is removed, these scenarios will no longer required NOE timely filing exception requests if the claims in the period are resubmitted later.

## Making changes to election period or benefit period information

When a hospice submits an NOTR (TOB 8xB), Medicare systems will post a revocation date on the new CWF election period screen and change the revocation indicator to 1. Similarly, if a revocation date is corrected using the 56/D0 process, the correct date will be displayed on the new CWF election period screen.

The hospice can take either of these actions regardless of whether a benefit period has been created by claims. This will remove a current barrier to prompt submission of NOTRs that also delays posting of subsequent NOEs. Removing this barrier will further reduce the need for NOE timely filing exceptions.

If the hospice files the discharge claim in lieu of the NOTR, the claims will also post the revocation date and revocation indicator on the new CWF election period screen, in addition to updating the TERM DATE of the benefit period to match the revocation date.

When a hospice submits a change of provider/transfer notice (TOB 8xC) or a change of ownership notice (TOB 8xE), this will make no changes to the new CWF election period screen. These transactions notify Medicare of the provider number that is allowed to bill for the beneficiary's hospice services, so an 8xC will post the START DATE2 on the hospice benefit period or an 8xE will post an OWNER CHANGE start date on the benefit period as they do today.

#### **NOTR submission changes**

These changes will require hospices to change how they submit the from date on an NOTR.

When there is no change in the provider number during the election, the hospice must submit the start date of the election period as the from date on the NOTR. In the past, the hospice submitted the start date of the current benefit period as the from date,

- so it is important for hospices to be aware of this new procedure.
- If the revocation follows a transfer, the from date on the NOTR must match the START DATE2 on the benefit period that initiated the transfer.
- If the revocation follows a change of ownership, the from date on the NOTR must match the OWNER CHANGE start date on the benefit periods. This process is to ensure that only the provider currently providing services to the beneficiary can submit the NOTR.
- In all cases, the admission date on the NOTR must continue to match the from date.

#### **Void/cancel submissions**

The hospice will continue to use TOB 8xD to:

- Remove an election period
- Remove a transfer that was submitted in error
- Remove a change of ownership that was submitted in error

As with NOTRs, hospices will need to be careful with the From date on the 8xD in order to remove the correct information.

- When there is no change in the provider number during the election, the hospice must submit the start date of the election period as the From date on the 8xD. Like today, all claims during the election must be cancelled before an election period can be removed.
- When there has been a transfer or change of ownership, the From date on the 8xD must match the corresponding transfer or change date to ensure those dates are removed correctly.

#### **Processing impacts**

Today, if a benefit period exists for a beneficiary and is not revoked, another NOE can be accepted for a later date as long at the From and Admission dates on the later NOE do not fall within the dates of the existing benefit period. With the conversion to election periods, a later NOE for the same beneficiary when there is no revocation date will be rejected with FISS reason code U5106. Consistent submission of revocations, via NOTRs or claims, within 5 days of the revocation date as required by regulation, will be increasingly important to prevent this edit.

Additionally, the first claim submitted by the hospice after an election must ensure the from and Admission dates match the election period start date. This will ensure the first benefit period in the election is created correctly and subsequent claims will process. Following existing sequential billing requirements will ensure this happens, but hospices may see an increase in claims rejected with FISS reason code U5181 otherwise.

#### **Summary chart**

The summary chart (see page 19) provides a reference to help hospices understand which of their submissions will impact an election period or a benefit period.

See HOSPICE, page 19



#### HOSPICE

from page 18

#### **Additional information**

If you have questions, your MACs may have more information. Find their website at <a href="https://go.cms.gov/MAC-website-list">https://go.cms.gov/MAC-website-list</a>.

#### **Document history**

Date of change	Description
June 7, 2018	Initial article released.

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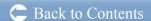
#### **Summary chart**

The following chart provides a reference to help hospices understand which of their submissions will impact an election period or a benefit period.

MLN Matters® Number: SE18007 Article Release Date: June 7, 2018 Related CR Transmittal Number: N/A Related Change Request (CR) Number: N/A

Effective Date: N/A Implementation N/A

	Effects of	election p	eriods	Effects of benefits periods		
Transaction type	Type of bill	Creates election period	Changes existing election period	Removes election period	Creates benefit period	Changes existing benefit period
Notice of election period	8xA	Always	OC 56 only	Never	Never	Never
Notice of termination/ revocation	8xB	Never	Always	Never	Never	Makes term date match revocation date
Transfer notice	8xC	Never	Never	Never	Only when no claims have created periods for previous hospice	Always
Void/cancel of election	8xD	Never	Never	Always	Never	Never
Change of ownership notice	8xE	Never	Never	Never	Only when no claims have created periods for previous hospice	Always
Admit thru discharge claim	8x1	Never	Adds revocation date and rev ind., if not a transfer	Never	Always	Always
Admission claim	8x2	Never	Never	Never	Always	Always
Continuing claim	8x3	Never	Never	Never	If OC 27 is present and "Through" date spans end of current period	Always
Discharge claim	8x4	Never	Adds revocation date and rev ind., If not a transfer	Never	Never	Always



## July 2018 update of the hospital outpatient prospective payment system

#### Provider type affected

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

#### Provider action needed

Change request 10781 describes changes to and billing instructions for various payment policies implemented in the July 2018 OPPS update. Make sure your billing staffs are aware of these changes.

#### **Background**

This recurring update notification describes changes to billing instructions for various payment policies implemented in the July 2018 OPPS update. The July 2018 I/OCE will reflect the HCPCS, ambulatory payment classification, HCPCS modifier, and revenue code additions, changes, and deletions identified in this CR.

#### Key changes in CR 10781

Key changes and billing instructions for various payment policies implemented in July 2018 OPPS updates are as follows:

## Multianalyte assays with algorithmic analyses (MAAA) CPT® coding changes effective April 1, 2018

The American Medical Association (AMA) *Current Procedural Terminology* (CPT®) editorial panel established two new MAAA codes, specifically, 0012M and 0013M, effective April 1, 2018. Because the codes were released March 1, 2018, it was too late to include them in the April 2018 OPPS update. Instead, the codes are being included in the July 2018 update with an effective date of April 1, 2018. Table 1 lists the long descriptor and status indicator (SI) for CPT® codes 0012M and 0013M.

Table 1 — Multianalyte assays with algorithmic analyses (MAAA) CPT<sup>®</sup> coding changes effective April 1, 2018

CPT® code	Long descriptor	OPPS	OPPS APC
0012M	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	A	N/A

CPT® code	Long descriptor	OPPS	OPPS APC
0013M	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	A	N/A

## Proprietary laboratory analyses (PLA) CPT<sup>®</sup> coding changes effective April 1, 2018

The AMA CPT® editorial panel established 10 new PLA CPT® codes, specifically, CPT® codes 0035U through 0044U effective April 1, 2018. Because the codes were released February 22, 2018, it was too late to include them in the January 2018 OPPS update. Instead, they are being included in the July 2018 update with an effective date of April 1, 2018.

Table 2 lists the long descriptors and status indicators for CPT® codes 0035U through 0044U. For more information on OPPS status indicators "A" and "Q4", refer to OPPS Addendum D1 of the 2018 OPPS/ambulatory surgical center (ASC) final rule. CPT® codes 0035U through 0044U have been added to the July 2018 I/OCE, with an effective date of April 1, 2018. These codes, along with their short descriptors and status indicators, are also listed in the July 2018 OPPS Addendum B.

Table 2 — Proprietary laboratory analyses (PLA) CPT<sup>®</sup> coding changes effective April 1, 2018

CPT® code	Long descriptor	OPPS SI	OPPS APC
0035U	Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative	Q4	N/A
0036U	Exome (i.e., somatic mutations), paired formalin-fixed paraffinembedded tumor tissue and normal specimen, sequence analyses	A	N/A

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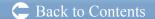
CPT® code	Long descriptor	OPPS SI	OPPS APC
0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden	A	N/A
0038U	Vitamin D, 25 hydroxy D2 and D3, by LC-MS/ MS, serum microsample, quantitative	Q4	N/A
0039U	Deoxyribonucleic acid (DNA) antibody, double stranded, high avidity	Q4	N/A
0040U	BCR/ABL1 (t (9;22)) (e.g., chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative	A	N/A
0041U	Borrelia burgdorferi, antibody detection of 5 recombinant protein groups, by immunoblot, IgM	Q4	N/A
0042U	Borrelia burgdorferi, antibody detection of 12 recombinant protein groups, by immunoblot, IgG	Q4	N/A
0043U	Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgM	Q4	N/A
0044U	Tick-borne relapsing fever Borrelia group, antibody detection to 4 recombinant protein groups, by immunoblot, IgG	Q4	N/A

Proprietary laboratory analysis (PLA) CPT® coding changes effective July 1, 2018

Effective July 1, 2018, the AMA CPT® editorial panel established 17 new PLA codes, specifically, CPT® codes 0045U through 0061U. Table 3, lists the long descriptors and status indicators for these codes. For more information on OPPS status indicators "A" and "Q4", refer to OPPS Addendum D1 of the 2018 OPPS/ambulatory surgical center (ASC) final rule. These codes, along with its short descriptors and status indicators, are also listed in the July 2018 OPPS Addendum B.

Table 3 — PLA CPT $^{\circ}$  coding changes effective July 1, 2018

2018				
CPT® code	Long descriptor	OPPS SI	OPPS APC	
0045U	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score	A	N/A	
0046U	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative	A	N/A	
0047U	Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin- embedded tissue, algorithm reported as a risk score	A	N/A	
0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraffinembedded tumor tissue, report of clinically significant mutation(s)	A	N/A	
0049U	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, quantitative	A	N/A	
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements	A	N/A	



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CPT® code	Long descriptor	OPPS SI	OPPS APC
0051U	Prescription drug monitoring, evaluation of drugs present by LC-MS/ MS, urine, 31 drug panel, reported as quantitative results, detected or not detected, per date of service	Q4	N/A
0052U	Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertical auto profile ultracentrifugation	Q4	N/A
0053U	Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade	A	N/A
0054U	Prescription drug monitoring, 14 or more classes of drugs and substances, definitive tandem mass spectrometry with chromatography, capillary blood, quantitative report with therapeutic and toxic ranges, including steady-state range for the prescribed dose when detected, per date of service	Q4	N/A
0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma	A	N/A
0056U	Hematology (acute myelogenous leukemia), DNA, whole genome next-generation sequencing to detect gene rearrangement(s), blood or bone marrow, report of specific gene rearrangement(s)	A	N/A

CPT® code	Long descriptor	OPPS SI	OPPS APC
0057U	Oncology (solid organ neoplasia), mRNA, gene expression profiling by massively parallel sequencing for analysis of 51 genes, utilizing formalin-fixed paraffinembedded tissue, algorithm reported as a normalized percentile rank	A	N/A
0058U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus oncoprotein (small T antigen), serum, quantitative	Q4	N/A
0059U	Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus capsid protein (VP1), serum, reported as positive or negative	Q4	N/A
0060U	Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal blood	A	N/A
0061U	Transcutaneous measurement of five biomarkers (tissue oxygenation [StO2], oxyhemoglobin [ctHbO2], deoxyhemoglobin [ctHbR], papillary and reticular dermal hemoglobin concentrations [ctHb1 and ctHb2]), using spatial frequency domain imaging (SFDI) and multi-spectral analysis	Q4	N/A

#### Category III CPT® codes effective July 1, 2018

The AMA releases Category III CPT® codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

For the July 2018 update, CMS is implementing four Category III CPT® codes that the AMA released in January 2018 for implementation July 1, 2018. The status indicators and APC assignments for these codes are shown in Table 4. Payment rates for these services can be found in Addendum B of the July 2018 OPPS update.

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Table 4 — Category III CPT® codes effective July 1, 2018

CPT® code	Long descriptor	OPPS SI	OPPS APC
0505T	Endovenous femoral- popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural road mapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	J1	5193
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report	Q1	5733
0507T	Near-infrared dual imaging (i.e., simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report	Q1	5733
0508T	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia	S	5522

#### Bilateral indicator for HCPCS code C9749

In the April 2018 OPPS update CR (Transmittal 4005, CR 10515, dated March 20, 2018), CMS announced the establishment of HCPCS code C9749 (Repair of nasal vestibular lateral wall stenosis with implant(s), effective April 1, 2018. CMS is also clarifying that this code describes an inherently bilateral procedure and that for unilateral procedures, hospital outpatient departments need to report either modifier 73 or 74. Modifiers 73 and 74 are only used to indicate discontinued procedures for which anesthesia is planned or provided.

## Packaging of CPT® code 01402 when reported with total knee arthroplasty (CPT® code 27447)

CPT® code 01402 describes anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty. For 2018, the status indicator assigned to this code is "C", which indicates that this is an inpatient procedure that is not paid for under the OPPS.

For the July 2018 update, when CPT® code 01402 is reported with CPT® code 27447, Arthroplasty, knee, condyle and plateau; medical and lateral compartments with or without patella resurfacing (total knee arthroplasty), this code is paid under the OPPS and payment for this service is packaged into the payment for CPT® code 27447. If the code is not reported with CPT® code 27447, the code is treated as an inpatient procedure that is not paid for under the OPPS. This change is retroactive to January 1, 2018.

#### Drugs, biologicals, and radiopharmaceuticals

## A. Drugs and biologicals with payments based on average sales price (ASP) effective July 1, 2018

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

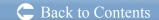
In 2018, a single payment of ASP + six percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates, effective July 1, 2018, and drug price restatements can be found in the *July 2018 update of the OPPS Addendum A and Addendum B*.

## B. Drugs and biologicals with OPPS pass-through status effective July 1, 2018

Six drugs and biologicals have been granted OPPS passthrough status, effective July 1, 2018. These items, along with their descriptors and APC assignments, are identified in Table 5.

Table 5 — Drugs and biologicals with OPPS passthrough status effective July 1, 2018

HCPCS code	Long descriptor	OPPS SI	OPPS APC
C9030	Injection, copanlisib, 1 mg	G	9030



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HCPCS code	Long descriptor	OPPS SI	OPPS APC
C9031	Lutetium Lu 177, dotatate, therapeutic, 1 mCi	G	9067
C9032	Injection, voretigene neparvovec-rzyl, 1 billion vector genome	G	9070
Q9991	Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg	G	9073
Q9992	Injection, buprenorphine extended-release (Sublocade), greater than 100 mg	G	9239
Q9995	Injection, emicizumab- kxwh, 0.5 mg	G	9257

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

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

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

## D. Other changes to 2018 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

Effective July 1, 2018, HCPCS code Q9993 (Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg) will replace HCPCS code C9469 (Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg). The status indicator will remain G, "pass-through drugs and biologicals". Table 6 (page 26) describes the HCPCS code change and effective date.

#### E. Change to status indicator for CPT® code 90739

Hepatitis B vaccine associated with CPT® code 90739 (Hepatitis b vaccine (hepb), adult dosage, two dose schedule, for intramuscular use) was approved by the Food and Drug Administration (FDA) November 09, 2017. Therefore, CMS is changing the status indicator for 90739 from SI=E1 (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type) to SI=F (Not paid under OPPS. Paid at reasonable cost.), effective April 1, 2018, in the July 2018 I/OCE update. Table 7 describes the status indicator change and effective date.

Table 7 — Change to status indicator for CPT<sup>®</sup> code 90739

CPT® code	Long descriptor	OPPS SI	Effective date
90739	Hepatitis b vaccine (hepb), adult dosage, 2 dose schedule, for intramuscular use	E1	January 1, 2013–March 31, 2018
90739	Hepatitis b vaccine (hepb), adult dosage, 2 dose schedule, for intramuscular use	F	April 1, 2018

## F. Drugs and biologicals with a change in status indicator

Two drugs, specifically, HCPCS codes J9216 and Q2049, listed in Table 8 have a change in status indicator from "K" to "E2" effective July 1, 2018, to indicate that CMS has no pricing information for both drug codes.

Table 8 — Drugs and biologicals with a change in status indicator

HCPCS code	Long descriptor	Old SI	New SI	Effective date
J9216	Injection, interferon, gamma 1-b, 3 million units	K	E2	7/1/18
Q2049	Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg	К	E2	7/1/18

## G. New biosimilar biological products effective July 1, 2018

Two new HCPCS codes will be created for reporting Retacrit, (epoetin alfa-epbx) as a biosimilar to Epogen/ Procrit (epoetin alfa) for the treatment of anemia caused by chronic kidney disease, chemotherapy, or use of zidovudine in patients with HIV infection. Retacrit is also approved for use before and after surgery to reduce the chance that red blood cell transfusions will be needed because of blood loss during surgery. Both codes are assigned to status indicator "K". These codes are listed in Table 9 and are effective for services furnished on or after July 1, 2018. Payment for each of these codes may be found in the July 2018 update of the OPPS Addendum B at <a href="https://www.cms.gov/HospitalOutpatientPPS/">https://www.cms.gov/HospitalOutpatientPPS/</a>.

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Table 9 — New HCPCS drug codes for Retacrit effective July 1, 2018

HCPCS code	Short descriptor	Long descriptor	OPPS SI	OPPS APC
Q5105	Inj Retacrit esrd on dialysi	Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units	К	9096
Q5106	Inj Retacrit non-esrd use	Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units	К	9097

#### Reassignment of skin substitute product from the lowcost group to the high-cost group

One skin substitute product, HCPCS code Q4178, has been reassigned from the low-cost skin substitute group to the high-cost skin substitute group based on updated pricing information. The product is listed in Table 10 (page 26).

Allow HCPCS code Q4116 (Alloderm, per square centimeter) to be billed with either revenue code 0278 (other implants) or revenue code 0636 (drugs requiring detailed coding)

HCPCS code Q4116 (Alloderm, per square centimeter) may be billed with either revenue code 0278 (Other implants) or revenue code 0636 (Drugs requiring detailed coding). HCPCS code Q4116 is used both as an applied skin substitute and as an implanted biologic used in breast reconstruction, and these procedures are reported with two different revenue codes. This request is described in Table 11 (page 26).

#### **Coverage determinations**

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



#### Additional information

The official instruction, CR 10781, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4075CP.pdf.

If you have questions, your MACs may have more information. Find their website at <a href="https://go.cms.gov/MAC-website-list">https://go.cms.gov/MAC-website-list</a>.

#### **Document history**

Date of change	Description
June 19, 2018	This article was revised to reflect an updated change request (CR). That update added new Retacrit codes Q5105 and Q5106 and new PLA codes 0045U - 0061U. Code Q9994 was also added for in-line cartridge containing digestive enzyme(s). These codes are effective July 1, 2018. CMS is also changing status indicators for two drug codes, The status indicator for J9216 and Q2049 were also changed from SI "K" to SI "E2" effective July 1, 2018. The CR release date, transmittal number and link to the transmittal also changed.
June 5, 2018	Initial article released.

MLN Matters® Number: MM10781 Related CR Release Date: June 15, 2018 Related CR Transmittal Number: R4075CP Related Change Request (CR) Number: 10781

Effective Date: July 1, 2018 Implementation July 2, 2018

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## July 2018 integrated outpatient code editor specifications

#### Provider type affected

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

#### Provider action needed

Change request (CR) 10699 provides the I/OCE instructions and specifications for the I/OCE that will be utilized under the outpatient prospective payment system (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the home health PPS (HH PPS) or to a hospice payment for the treatment of a non-terminal illness. Please make sure your billing staffs are aware of these updates.

#### **Background**

CR 10699 informs the Part A/B MACs Part A, the A/B MACs Part home health and hospice (HHH) and the fiscal intermediary shared system (FISS) that the I/OCE is being updated for July 1, 2018. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single I/OCE.

The I/OCE is used under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under HH

PPS or to a hospice patient for the treatment of a non-terminal illness.

The modifications of the I/OCE for the July 2018 V19.2 release are summarized in the table below. Readers should also read through the entire specifications document and note the highlighted sections, which also indicate changes from the prior release of the software. I/OCE specifications will be posted on the Centers for Medicare & Medicaid Services (CMS) website at <a href="https://www.cms.gov/OutpatientCodeEdit/">https://www.cms.gov/OutpatientCodeEdit/</a>.

Table 1: July 2018 I/OCE modifications

Effective date	Edits affected	Modification
1/1/18	18	Implement new program logic retroactively (1/1/18) to allow anesthesia code 01402 (status Indicator (SI) = C) reported with procedure code 27447 to package by changing its SI from C to N. If 01402 is reported with any other procedure the SI remains a C and will process as usual.
1/1/16	38	Update program logic retroactively (1/1/16) to exclude procedures with SI=J2 from satisfying edit 38.

See IOCE, page 27

#### **HOPPS**

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Table 6 — Other changes to 2018 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

HCPCS code	Long descriptor	OPPS SI	OPPS APC	Effective date	Term date
C9469	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	G	9469	4/1/18	6/30/18
Q9993	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	G	9469	7/1/18	

**Note:** HCPCS code Q9994 (In-line cartridge containing digestive enzyme(s) for enteral feeding, each) will also be added and is listed in the upcoming July 2018 I/OCE CR, effective July 1, 2018.

Table 10 - Reassignment of skin substitute product from the low-cost group to the high-cost group effective July 1, 2018

HCPCS code	Short descriptor	OPPS SI	Low/high cost skin substitute
Q4178	Floweramniopatch, per sq cm	N	High

Table 11 — Allow HCPCS code Q4116 (Alloderm, per square centimeter) to be billed with either revenue code 0278 (other implants) or revenue code 0636 (drugs requiring detailed coding)

HCPCS code	Short descriptor	OPP SI	Allowed revenue codes for billing
Q4116	Alloderm, per square centimeter	N	0278, 0636

#### **IOCE**

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Effective date	Edits affected	Modification
4/1/18		Update logic for add-on code editing to apply the applicable edits on both add-on procedure line items, if reporting multiple add-on codes without one or both primary procedures.
7/1/18		Update the program logic to include edits (6, 20, 22, 40, 106, 107, and 108) to applicable bill types retroactively to the edits activation date. This includes the documentation update to the edits applied by bill type tables, see table for updates.
7/1/18	6,22	Implement logic to include a condition in which lines submitted on a 32x bill type (HHA) with revenue code 0023 do not have edit 6 or 22 applied.
7/1/18	22	Add the following new modifier to the valid modifier list QO – Qualified cdsm consulted
7/1/18		Update the add-on code editing section to include additional conditions for editing. This includes an update to the edit descriptions and reason for edit generation table.
7/1/18		Update the I/OCE execution and processing flowchart to include rural health clinic (RHC) in the federally qualified health center (FQHC) objects mentioned in processing.
7/1/18		Update to hospice processing section to note the logic that is discontinued by edit 61 and 72 being removed from bill type 81x and 82x (1/1/14).
7/1/18		Update to biosimilar HCPCS processing section to note that Edits 94 and 103 are discontinued, effective 4/1/18
7/1/18		Update the pass-through device processing section to change language from device-intensive procedure pairing to procedure and pass-through device pairings.
7/1/18		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).

Effective date	Edits affected	Modification
7/1/18		Update the following lists for the release (see quarterly data files):  Add on type I (edit 106)
		<ul> <li>Add on type II (edit 107)</li> <li>Add on type III (edit 108)</li> <li>Comprehensive ambulatory payment classification (APC) ranking</li> </ul>
		<ul> <li>Comprehensive APC exclusions</li> </ul>
		Procedure and sex conflict (edit 8)
		<ul> <li>RHC CG modifier not payable</li> <li>Skin substitute product (edit 86)</li> <li>Non-covered service (edit 9)</li> <li>Service not paid by Medicare (edit 13)</li> </ul>
7/1/18	20, 40	Implement version 24.2 of the National Correct Coding Initiative (NCCI) (as modified for applicable outpatient institutional providers).

#### **Additional information**

The official instruction, CR 10699, issued to your MAC regarding this change is available at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4074CP.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4074CP.pdf</a>.

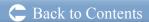
If you have questions, your MACs may have more information. Find their website at <a href="https://go.cms.gov/MAC-website-list">https://go.cms.gov/MAC-website-list</a>.

#### **Document history**

Date of change	Description
June 18, 2018	This article was revised to reflect an updated CR that made revisions to the summary of changes and summary of modifications documents. In the article "Service not paid by Medicare (edit 13)" was added in the table in the <i>Background</i> section.
June 6, 2018	Initial article released.

MLN Matters® Number: MM10699 Related CR Release Date: June 15, 2018 Related CR Transmittal Number: R4074CP Related Change Request (CR) Number: 10699

Effective Date: July 1, 2018 Implementation July 2, 2018



## Quarterly update to the ESRD prospective payment system

#### 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 ESRD services provided to Medicare beneficiaries.

#### Provider action needed

Change request (CR) 10818 provides instructions for new codes added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management that will be included in the list of items and services subject to the ESRD PPS consolidated billing (CB) requirements. Make sure your billing staff is aware of the changes.

#### Background

Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) required the implementation of an ESRD PPS, effective January 1, 2011.

The ESRD PPS:

- Includes consolidated billing requirements for limited Part B services included in the ESRD facility's bundled payment
- Provides ESRD facilities a single payment that covers all of the resources used to furnish an outpatient dialysis treatment
- Provides outlier payments, if applicable, for high cost patients due to unusual variations in the type or amount of medically necessary care.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services subject to Part B CB, and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

CR 10818 provides instructions for a new code (Q5105 - Injection, epoetin alfa, biosimilar, (Retacrit) 100 units (for esrd on dialysis)) added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management; and which will be included in the list of items and services subject to the ESRD PPS CB requirements, effective July 1, 2018. This code will be reportable with revenue code 0634 or 0635 on the 72x type of bill for ESRD beneficiaries.

Anemia management is a functional category under the ESRD PPS, and the drugs and biologicals that fall within this category are always considered to be used for the treatment of ESRD. Further, in accordance with 42 CFR 413.237(a)(1), HCPCS Q5105 is considered to be an eligible outlier service and will be included in the outlier calculation. If the pricing data is not available on the ASP drug file, then MACs will manually price the drug using 1847A pricing methodologies. ESRD facilities will not

receive separate payment for Q5105, with or without the AY modifier (Item or service furnished to an ESRD patient that is not for the treatment of ESRD), and the claims will process the line item as covered with no separate payment under the ESRD PPS.

In addition, there is a new HCPCS code - Q5106 (Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units). This code will be reportable with revenue code 0636 on the 72x type of bill for individuals with acute kidney injury (AKI). Q5106 is paid for through the AKI payment rate and therefore separate payment is not allowable on the 72x type of bill.

The updated list of renal dialysis services that are subject to the ESRD PPS CB requirements is available at <a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated\_Billing.html">https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated\_Billing.html</a>. Also, CR 10818 has an attachment that is a list of drugs always considered ESRD.

#### Additional information

The official instruction, CR 10818, issued to your MAC regarding this change is available at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4073CP.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Guidance/Transmittals/2018Downloads/R4073CP.pdf</a>.

If you have questions, your MACs may have more information. Find their website at <a href="https://go.cms.gov/MAC-website-list">https://go.cms.gov/MAC-website-list</a>.

#### **Document history**

Date of change	Description
June 19, 2018	This article was revised to add information on the revenue codes to be used for reporting code Q5105 on the 72x type of bill for ESRD beneficiaries. All other information remains the same.
June 15, 2018	Initial article released.

MLN Matters® Number: MM10818 Related CR Release Date: June 15, 2018 Related CR Transmittal Number: R4073CP Related Change Request (CR) Number: 10818

Effective Date: July 1, 2018 Implementation July 2, 2018

## July update to the 2018 Medicare physician fee schedule database

#### Provider type affected

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

#### Provider action needed

Change request (CR) 10644 amends payment files issued to MACs based upon 2018 Medicare physician fee schedule (MPFS) final rule. Make sure your billings staffs are aware of these changes.

#### **Background**

The Centers for Medicare & Medicaid Services (CMS) issued payment files to the MACs based upon the 2018 Medicare physician fee schedule (MPFS) final rule, published in the *Federal Register* November 15, 2017, to be effective for services furnished between January 1, 2018, and December 31, 2018.

CR 10644 presents a summary of the changes for the July update to the 2018 MPFSDB. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2018. The following tables show those changes.

,	· ·
CPT®/HCPCS & mod	Action
G0511	Change PC/TC indicator to "0"
G0512	Change PC/TC indicator to "0"
G0460*	Change status = A, work RVU = 2.25, non-facility PE RVU = 2.89, facility PE RVU = .94, malpractice RVU = .34, mult proc = 2, bilat surg = 0, asst surg = 1, co-surg = 0, team surge = 0, global days = 000
71045	Facility and non-facility PE RVU changed to 0.42
71045 TC	Facility and non-facility PE RVU changed to 0.35

\* The work RVU of G0460 was valued at the work RVU of one billing of *Current Procedural Terminology* (CPT®) code 11042 (1.01) plus two billings of CPT® code 11045 (0.50), along with a single billing of CPT® codes 99195 (0.00) and 38213 (0.24) to cover the lab portion of the work. The direct PE inputs were cross walked from CPT® code 11042 along with the inclusion of additional clinical labor, supplies, and equipment based on CMS determination of what would be typical and medically necessary for the procedure.

The following "Q" codes are effective for services performed on or after July 1, 2018, (see *MM10624* for additional information).

Code	Action
Q9991	Procedure status = E; there are no RVUs, payment policy indicators do not apply
Q9992	Procedure status = E; there are no RVUs, payment policy indicators do not apply
Q9993	Procedure status = E; there are no RVUs, payment policy indicators do not apply
Q9995	Procedure status = E; there are no RVUs, payment policy indicators do not apply

The following new CPT® category III codes have been added for dates of service July 1, 2018, and after:

Code	Short descriptor	Long descriptor
0505T	Ev fempop artl revsc	Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion
0506T	Mac pgmt opt dns meas hfp	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report
0507T	Near ifr 2img mibmn glnd i&r	Near-infrared dual imaging (ie, simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report
0508T	Pls echo us b1 dns meas tib	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia

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

See MPFSDB, page 30

#### **MPFSDB**

from page 29

**Note**: Policy indicators for new CPT® category III codes 0505T-0508T may be found at the bottom of this page.

#### Additional information

The official instruction, CR 10644, issued to your MAC regarding this change is available at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4053CP.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Guidance/Transmittals/2018Downloads/R4053CP.pdf</a>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <a href="https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html">https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html</a>.

#### **Document history**

Date of change	Description
May 21, 2018	Initial article released.

MLN Matters® Number: MM10644 Related CR Release Date: May 18, 2018 Related CR Transmittal Number: R4053CP Related Change Request (CR) Number: 10644



Effective Date: January 1, 2018 Implementation July 2, 2018

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#### Policy indicators for new CPT® category III codes 0505T-0508T

HCPCS/ Mod	0505T	0506T	0506T- 26	0506T- TC	0507T	0507T- 26	0507T- TC	0508T	0508T- 26	0508T- TC
Status	С	С	С	С	С	С	С	С	С	
Muti	0	7	7	7	7	7	7	7	7	7
Bilat	0	0	0	0	0	0	0	0	0	0
Asst Surg	0	0	0	0	0	0	0	0	0	0
Co-surg	0	0	0	0	0	0	0	0	0	0
Team surg	0	0	0	0	0	0	0	0	0	0
PC/TC	0	1	1	1	1	1	1	1	1	1
Global	YYY	XXX	xxx	xxx	XXX	XXX	xxx	XXX	xxx	XXX
Diag supv	09	09	09	01	09	09	01	09	09	01
Diag imag	99	99	99	99	99	99	99	99	99	99

Note: Pre, intra and post-operative percentages for CPT® codes 0505T-0508T are all "0.00

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

#### Provider type affected

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

#### Provider action needed

Change request (CR) 10667 instructs MACs to download and implement the July 2018 and, if released, the revised April, 2018, January 2018, October 2017, and July 2017 ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) data center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 2, 2018, with dates of service July 1, 2018, through September 30, 2018. Make sure that your billing staffs are aware of these changes.

#### **Background**

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

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

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



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

#### Additional information

The official instruction, CR 10667, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4061CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <a href="https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html">https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html</a>.

#### **Document history**

Date of change	Description
May 25, 2018	Initial article released.

MLN Matters® Number: MM10667 Related CR Release Date: May 25, 2018 Related CR Transmittal Number: R4061CP Related Change Request (CR) Number: 10667

Effective Date: July 1, 2018 Implementation July 2, 2018



### July quarterly update for 2018 DMEPOS fee schedule

#### Provider type affected

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

#### Provider action needed

Change request (CR) 10707 provides the July 2018 Medicare DMEPOS fee schedule quarterly update listing fee schedule amounts for non-rural and rural areas. Additionally, the parenteral and enteral nutrition (PEN) fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parental nutrition items. Also, the files for this update include the July 2018 DMEPOS rural ZIP code file containing the third quarter 2018 rural ZIP code changes.

#### **Background**

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

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. Section 1842(s) (3)(B) of the Act provides authority for adjusting the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

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

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

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

Key changes in this update are as follows:

#### Interim final rule with comment period (CMS-1687-IFC)

The interim final rule with comment period (CMS-1687-IFC) titled Transitional 50/50 blended rates to provide relief in rural areas and non-contiguous areas was published in the Federal Register Friday, May 11, 2018. The IFC amends the regulations to increase the fee schedule amounts for items furnished from June 1, 2018, through December 31, 2018, in rural areas and non-contiguous areas (Alaska, Hawaii, and United States territories) not subject to the CBP. This change requires new 2018 rural and non-contiguous fee schedules be calculated for HCPCS codes for certain DME and PEN adjusted using competitive bidding information effective June 1, 2018. The new rural and non-contiguous fee schedule amounts are based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amounts updated by the covered item updates specified in Sections 1834(a)(14) and 1842(s)(B) of the Act. For areas other than rural or non-continuous areas, the fee schedules for DME and PEN codes with adjusted fee schedule amounts will continue to be based on 100 percent of the adjusted fee schedule amounts from June 1. 2018, through December 31, 2018.

Because the revised rural and non-contiguous fee schedule amounts are based in part on unadjusted fee schedule amounts, the fees for certain items included in the 2008 original round one CBP, denoted with the HCPCS pricing modifier, are added back to the fee schedule file only for items furnished in rural and non-contiguous areas. Background information and a list of the applicable KE HCPCS codes was issued in Transmittal 1630, CR 6270, dated November 7, 2008. (See the related MLN Matters® article MM6270 at https://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/ MLNMattersArticles/Downloads/MM6270.pdf.) Beginning June 1, 2018, through December 31, 2018, the rural and non-contiguous KE fee schedule amounts will be based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted KE fee schedule amount updated by the covered item updates specified in Sections 1834(a)(14) and 1842(s)(B) of the Act. The non-rural fees for these KE codes will be populated with zeros on the fee schedule file since KE is not a valid option for areas without blended fees.

See **DMEPOS**, page 33

#### **DMEPOS**

from page 32

For certain accessories used with base equipment included in the CBP in 2008 (for example, power wheelchairs, walkers, and negative pressure wound therapy pumps), the unadjusted fee schedule amounts include a 9.5 percent reduction in accordance with Federal law if these accessories were also included in the 2008 CBP. The 9.5 percent fee reduction only applies to these accessories when they are furnished for use with the base equipment included in the 2008 CBP. Beginning June 1, 2018, in cases where accessories included in the 2008 CBP are furnished for use with base equipment that was not included in the 2008 CBP (for example, manual wheelchairs, canes and aspirators), for beneficiaries residing in rural or non-contiguous, non-competitive bid areas, suppliers should append the KE modifier to the HCPCS code for the accessory. Suppliers should not use the KE modifier with accessories that were included in the 2008 CBP and furnished for use with base equipment that was not included in the 2008 CBP when these accessories are furnished to beneficiaries residing in non-rural, noncompetitive bid areas.

Also, because the IFC results in a change to the 2018 fee schedule amounts for the various classes of oxygen and oxygen equipment, the annual oxygen budget neutrality adjustment for 2018 is recomputed and the adjustments to the stationary oxygen equipment, mandated by regulations at Section 414.226(c)(6), will be applied to the fees on the June 1, 2018 file.

DMEPOS and PEN fee schedule files containing the revised rural and non-contiguous 50/50 blend fees were transmitted in May to the Part B and DME MACs for the June 1, 2018, implementation. However, the DMEPOS institutional claim (FI) fee schedule file was not updated with the revised rural and non-contiguous 50/50 blend in June. The July 2018 DMEPOS fee schedule FI file will incorporate the 50/50 blend rural and non-contiguous fees with a June 1, 2018, effective date. As part of the July 2018 DMEPOS fee schedule file update, HHHMACs shall adjust any impacted 50/50 blend claims processed for dates of service between June 1, 2018, and June 30, 2018, that are brought to their attention by the supplier.

MACs will not search for and adjust claims for HCPCS codes with revised 50/50 blend fees appearing on the July 2018 DMEPOS FI file with effective dates of June 1, 2018, for dates of service June 1, 2018, through June 30, 2018. However, they will adjust these claims when you bring them to their attention for dates of service June 1, 2018, through June 30, 2018.

#### Other changes

As part of this update, the fee schedules for HCPCS code



Q0477 (power module patient cable for use with electric or electric/pneumatic ventricular assist device, replacement only) are revised and effective for dates of service on or after January 1, 2018. If you resubmit impacted claims, MACs will adjust previously processed claims for code Q0477 with dates of service on or after January 1, 2018.

The fee schedules public use files (PUFs) will be available for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the data files at <a href="https://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/DMEPOSFeeSched/DMEPOS-FeeSched/DMEPOS-FeeSchedule.html">https://www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/DMEPOSFeeSched/DMEPOS-FeeSchedule.html</a>.

#### Additional information

The official instruction, CR 10707, issued to your MAC regarding this change is available at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Guidance/Guidance/Guidance/Guidance/Transmittals/2018Downloads/R4072CP.pdf">https://www.cms.gov/Regulations-and-Guidance/Guida

If you have questions, your MACs may have more information. Find their website at <a href="https://go.cms.gov/MAC-website-list">https://go.cms.gov/MAC-website-list</a>.

#### **Document history**

Date of change	Description
June 11, 2018	Initial article released.

MLN Matters® Number: MM10707 Related CR Release Date: June 8, 2018 Related CR Transmittal Number: R4072CP Related Change Request (CR) Number: 10707

Effective Date: January 1, 2018, for fees for code Q0477; June 1, 2018, for CMS-1687-IFC-related rural and blended fees; July 1, 2018, for all other changes

Implementation July 2, 2018

## **E/M service documentation provided by students – manual update**

Note: This article was revised June 1, 2018, to reflect an updated change request (CR) that corrected typos in the CR and part of the manual update under Section 100.1.1. The transmittal number, CR released date and link to the transmittal also changed. All other information is unchanged. This information was previously published in the February 2018 Medicare A Connection, page 14.

#### Provider type affected

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

#### Provider action needed

CR 10412 revises the *Medicare Claims Processing Manual* to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Make sure your billing staffs are aware of the changes.

#### **Background**

The Centers for Medicare & Medicaid Services (CMS) is revising the *Medicare Claims Processing Manual*, Chapter 12, Section 100.1.1, to update policy on evaluation and management (E/M) documentation to allow the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work. Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.

#### Additional information

The official instruction, CR 10412, issued to your MAC regarding this change is available at <a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4068CP.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Guidance/Transmittals/2018Downloads/R4068CP.pdf</a>.

If you have questions, your MACs may have more information. Find their website at <a href="https://go.cms.gov/MAC-website-list">https://go.cms.gov/MAC-website-list</a>.



#### **Document history**

Date of change	Description
June 1, 2018	This article was revised to reflect an updated CR that corrected typos in the CR and part of the manual update under Section 100.1.1. The transmittal number, CR released date and link to the transmittal also changed.
February 5, 2018	Initial article released.

MLN Matters® Number: MM10412 Revised
Related CR Release Date: May 31, 2018
Related CR Transmittal Number: R4068CP
Related Change Request (CR) Number: 10412

Effective Date: January 1, 2018 Implementation March 5, 2018

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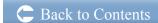
#### **IDTF**

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MLN Matters® Number: MM10735 Related CR Release Date: June 8, 2018 Related CR Transmittal Number: R4071CP Related Change Request (CR) Number: 10735

Effective Date: July 9, 2018

#### Implementation July 9, 2018



## **Upcoming provider outreach and educational events**

#### Topic: Medicare Part A changes and regulations

Date: Wednesday, September 12

Time: 10:00-11:30 a.m. Type of Event: Webcast

https://medicare.fcso.com/Events/0409580.asp

**Topic: Medicare Speaks 2018 Panama City** 

Date: Wednesday-Thursday, November 7-8

Time: 8:00 a.m.-4:30 p.m. Type of Event: Face-to-face

https://medicare.fcso.com/medicare\_speaks/0404329.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 <a href="https://gm1.geolearning.com/geonext/fcso/opensite.geo">https://gm1.geolearning.com/geonext/fcso/opensite.geo</a>, 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:	
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.

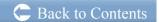
#### Never miss a training opportunity

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.

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Medicare Learning Network

go.cms.gov/mln



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 May 24, 2018

MLN Connects® for May 24, 2018 View this edition as a PDF

#### **News & Announcements**

- MIPS Promoting Interoperability Performance Category
- Provider Documentation Manual on Home Use of Oxygen: Submit Comments on Draft by May 31
- Proposals for New Measures for Promoting Interoperability Program: Deadline June 29
- Targeted Probe and Educate Video
- Hospice Compare Quarterly Refresh
- CQM Annual Update
- Break Free from Osteoporosis

#### **Provider Compliance**

 Medicare Hospital Claims: Avoid Coding Errors — Reminder

#### Claims, Pricers & Codes

FY 2019 ICD-10-PCS Procedure Codes

#### **Upcoming Events**

- Hospice Quality Reporting Program Data Submission and Reporting Webinar — May 30
- DMEPOS Dietary Related Items, Templates and CDEs Special Open Door Forum — May 31
- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6
- MIPS Promoting Interoperability Performance Category Webinar — June 12

## Medicare Learning Network Publications & Multimedia

RARC, CARC, MREP, and PC Print Update MLN



Matters Article — New

- Implement Operating Rules Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE MLN Matters Article
   New
- Removal of KH Modifier from Capped Rental Items MLN Matters Article — Revised
- Changes to the ESRD Claim to Accommodate Dialysis Furnished to Beneficiaries with AKI MLN Matters Article — Revised
- World of Medicare Web-Based Training Course Revised
- Your Office in the World of Medicare Web-Based Training Course — Revised
- Your Institution in the World of Medicare Web-Based Training Course — Revised

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### MLN Connects® for May 31, 2018

MLN Connects® for May 31, 2018 View this edition as a PDF

#### **News & Announcements**

- New Medicare Card Project Card Mailing Update
- MIPS: Submit Quality Measures for Consideration by June 1
- 2016 Physician and Other Supplier PUF
- 2016 Referring Provider DMEPOS PUF

#### **Provider Compliance**

 Provider Minute Video: The Importance of Proper Documentation

#### Upcoming Events

- Qualified Medicare Beneficiary Program Billing Requirements Call — June 6
- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call June 21

## Medicare Learning Network Publications & Multimedia

- New Medicare Beneficiary Identifier: Get It, Use It MLN Matters Article — New
- Quarterly Update to the Medicare Physician Fee Schedule Database MLN Matters Article — New
- Quarterly Update for the DMEPOS CBP MLN Matters Article — New
- Quarterly ASP Part B Drug Pricing Files and Revisions to Prior Files MLN Matters Article — New
- MCReF System Webcast: Video Presentation New
- Quality Payment Program Call: Audio Recording and Transcript — New
- Diagnosis Code Update for Add-on Payments for Blood Clotting Factor Administered to Hemophilia Inpatients MLN Matters Article — Revised

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### MLN Connects® for June 7, 2018

MLN Connects® for June 7, 2018 View this edition as a PDF

#### **News & Announcements**

- New Medicare Card: MBI Look-up Tool Available through your MAC
- Declines in Hospital-Acquired Conditions Save 8,000 Lives and \$2.9 Billion
- 2017 Quality Payment Program Year 1 Submission Results
- DMEPOS Prior Authorization List Additions
- Draft QRDA III Implementation Guide: Submit Comments by June 20
- IRF and LTCH Provider Preview Reports: Review Your Data by June 30
- SNF Provider Preview Report: Review Your Data by June 30
- Hospice Provider Preview Reports: Review Your Data by June 30
- Eligible Hospitals: Submit a Hardship Exception Application by July 1
- PEPPER for Short-term Acute Care Hospitals
- View Your MIPS Preliminary Performance Feedback Data
- Physician Compare Downloadable Database: 2016 Performance Scores

#### **Provider Compliance**

 Bill Correctly for Device Replacement Procedures — Reminder

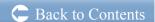
#### **Upcoming Events**

- MIPS Promoting Interoperability Performance Category Webinar — June 12
- CMS Quality Measures: Development,
   Implementation, and You Webinar June 13 or 14
- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call June 21
- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28
- Comparative Billing Report on Knee Orthoses Referring Providers Webinar — July 11

## Medicare Learning Network Publications & Multimedia

- New Q Code for In-Line Cartridge Containing Digestive Enzyme(s) MLN Matters Article — New
- July 2018 Update of the Ambulatory Surgical Center Payment System MLN Matters Article — New
- Claim Status Category and Claim Status Codes Update MLN Matters Article — New
- Settlement Conference Facilitation Call: Audio Recording and Transcript — New
- E/M Service Documentation Provided by Students MLN Matters Article — Revised

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### MLN Connects® for June 14, 2018

MLN Connects® for June 14, 2018 View this edition as a PDF

#### **News & Announcements**

- CMS Opioids Roadmap
- LTCH and IRF Compare Refresh
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Men's Health Week Ends on Father's Day

#### **Provider Compliance**

Billing for Stem Cell Transplants — Reminder

#### Claims, Pricers & Codes

FY 2019 ICD-10-CM Diagnosis Codes

#### **Upcoming Events**

- Medicare Diabetes Prevention Program: Supplier Enrollment Call — June 20
- IMPACT Act: Frequently Asked Questions Call June 21
- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28

## Medicare Learning Network Publications & Multimedia

- Improvements in Hospice Billing and Claims Processing MLN Matters Article — New
- Provider Enrollment: Unlicensed Residents MLN Matters Article — New
- Update of the Hospital OPPS: July 2018 MLN Matters Article — New
- I/OCE Specification Version 19.2: July 2018 MLN Matters Article — New
- Quarterly Update for the DMEPOS CBP: October 2018
   MLN Matters Article New
- Medicare Claims Processing Manual Update, Chapters 18 and 35: IDTF MLN Matters Article — New
- Provider/Supplier Reporting of Adverse Legal Actions MLN Matters Article — New
- Transition to New Medicare Numbers and Cards Fact Sheet — Revised
- CMS Web Wheel Educational Tool Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-based Training — Reminder
- Remittance Advice Resources and FAQs Booklet Reminder

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### MLN Connects® for June 21, 2018

MLN Connects® for June 21, 2018 View this edition as a PDF

#### **News & Announcements**

- New Medicare Cards May Have QR Codes
- Continuous Glucose Monitors: Changes Impacting Medicare Coverage
- Quality Payment Program Look-Up Tool Updated
- Quality Payment Program Website Includes 2018 MIPS Measures and Activities
- Hospice Provider Preview Reports: Review Your Data by June 30
- IRF and LTCH Provider Preview Reports: Review Your Data by July 1
- SNF Provider Preview Report: Review Your Data by July 1
- CMS Leverages Medicaid Program to Combat the Opioid Crisis

#### **Provider Compliance**

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

#### **Upcoming Events**

- Home Health Agencies: Quality of Patient Care Star Ratings Algorithm Call — June 27
- Ground Ambulance Providers and Suppliers: Data Collection System Listening Session — June 28

## Medicare Learning Network Publications & Multimedia

- July Quarterly Update for 2018 DMEPOS Fee Schedule MLN Matters Article — New
- Qualified Medicare Beneficiary Call: Audio Recording and Transcript — New

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#### **First Coast Service Options Phone Numbers**

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

#### **Customer service**

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

#### Electronic data interchange

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

#### **Interactive Voice Response** 877-602-8816

#### Provider education/outreach

**Event registration hotline** 904-791-8103

#### **Overpayments**

904-791-8123

#### **SPOT Help Desk**

FCSOSPOTHelp@fcso.com 855-416-4199

#### **Websites**

medicare.fcso.com medicareespanol.fcso.com

#### **First Coast Service Options Addresses**

#### Claims/correspondence

#### Florida/ U.S. Virgin Islands

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

#### **Puerto Rico**

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

#### **Medicare EDI** Electronic claim filing

**Direct Data Entry** P. O. Box 44071 Jacksonville, FL 32231-4071

#### Fraud and abuse

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

#### **FOIA** requests

#### Provider audit/reimbursement

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

#### **General Inquiries**

Online Form (Click here)

Email: EDOC-CS-FLINQA@fcso.com

#### Local coverage determinations

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

#### Medicare secondary payer (MSP)

Medicare Secondary Payer P. O. Box 2711 Jacksonville, FL 32231-0021

#### **Hospital audits**

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

#### MSPRC DPP debt recovery, auto accident settlements/lawsuits, liabilities

Auto/Liability - 17T P. O. Box 44179 Jacksonville, FL 32231-4179

#### Overpayment collections and debt recovery

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

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

#### **Credit balance reports**

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

#### Post-pay medical review

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

#### **Provider enrollment**

CMS-855 Applications P. O. Box 44021 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, takehome 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