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

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Quarterly influenza virus vaccine code update – January 2019

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) 10871 provides instructions for payment and edits for Medicare's common working file (CWF) and fiscal intermediary shared system (FISS) to include and update new or existing influenza virus vaccine codes. This update includes one new influenza virus vaccine code: 90689. Please make certain your billing staffs are aware of this update.

Background

Effective for claims processed with dates of service (DOS) on or after January 1, 2019, influenza virus vaccine code 90689 (*Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use)* will be payable by Medicare. The short descriptor is VACC IIV4 NO PRSRV 0.25ML IM.

This new code will be included on the 2019 Medicare physician fee schedule catabase file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

Except as noted below, MACs will use the Centers for Medicare & Medicaid Services (CMS) seasonal influenza vaccines pricing webpage: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* to obtain the payment rate for 90689.The new influenza virus vaccine code 90689 is not retroactive to August 1, 2018. No claims should be accepted for influenza virus vaccine code 90689 between the DOS August 1, 2018, and December 31, 2018. If claims are received in January 2019 with code 90689 for DOS between August 1, 2018, and December 31, 2018, MACs will follow their normal course of action for codes billed prior to their effective date.

Payment basis for institutional claims

MACs will pay for influenza virus vaccine code 90689 with a type of service (TOS) of V based on reasonable cost to

- Hospitals (type of bill 12x and 13x)
- Skilled nursing facilities (22x and 23x)

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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.

Clarification of policies related to reasonable cost payment for nursing and allied health education programs

Background

Payment for provider-operated programs

A program is considered to be provider-operated if the hospital meets the criteria specified in § 413.85(f), which means the hospital directly incurs the training costs, controls the curriculum and the administration of the program, employs the teaching staff, and provides and controls both classroom and clinical training (where applicable) of the NAH education program.

Payment for certain non-provider-operated programs

Section 4004(b)(1) of Pub. L. 101-508 provides an exception to the requirement that programs be provider-operated to receive pass-through payments. This section provides that, if certain conditions are met, the costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) for clinical training conducted on the premises of the hospital under an approved NAH education program that is not provider-operated by the hospital are treated as pass-through costs and paid on the basis of reasonable cost. Section 4004(b)(2) of Pub. L. 101-508 sets for the conditions that a hospital must meet to receive payment on a reasonable cost basis under Section 4004(b)(1). These provisions are codified in the regulations at § 413.85(g).

Policy

I. Clarification regarding provider-operated programs

The regulations regarding provider-operated programs at § 413.85 are as follows:

(f) ***Criteria for identifying programs operated by a provider***.

(1) Except as provided in paragraph (f)(2) of this section, for cost reporting periods beginning on or after October 1, 1983, in order to be considered the operator of an approved nursing or allied health education program, a provider must meet all of the following requirements:

(i) Directly incur the training costs.

(ii) Have direct control of the program curriculum. (A provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider must provide all of the courses relating to the theory and practice of the nursing or allied health profession involved that are required for the degree, diploma, or certificate awarded at the completion of the program.)

(iii) Control the administration of the program, including collection of tuition (where applicable), control the maintenance of payroll records of teaching staff or students, or both (where applicable), and be responsible for day-to-day program operation. (A provider may contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions.)

(iv) Employ the teaching staff.

(v) Provide and control both classroom instruction and clinical training (where classroom instruction is a requirement for program completion), subject to the parenthetical sentence in paragraph (f)(1)(ii) of this section.

(2) Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) of this section and to be the operator of the program.

We have received questions about §413.85(f)(2), which states, "Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) of this section and to be the operator of the program." We are clarifying our existing policy below; we are not changing policy on this matter.

As the accreditation requirements have evolved and the trend in nursing and allied health education has grown toward degree-issuing programs from colleges or universities, hospitals have tried to restructure their programs and make arrangements with colleges or universities in order to simultaneously provide a degree to their graduates, and meet the provider-operated criteria. However, successfully satisfying the provider-operated criteria in order to qualify for Medicare pass-through payment while simultaneously meeting current accreditation requirements has become extremely difficult, if not impossible, in certain circumstances. It is a reality that many previously provider-operated programs are no longer compliant with all provider-operated criteria at §413.85(f)(1), and should not be receiving Medicare pass-through payments. We stress that *in all cases, the burden of proof is on the hospital to demonstrate that its program is meeting the five criteria listed at §413.85(f)(1) for provider-operated status.* The MAC shall not assume that because the hospital issues the degree, diploma, or certificate of completion, either individually, or jointly

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with a college/university, that that is sufficient to meet the provider-operated criteria. It is not sufficient. As §413.85(f)(2) states, "**Absent evidence to the contrary**, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) of this section and to be the operator of the program" (emphasis added). This bolded language, "absent evidence to the contrary," indicates that the hospital *must first demonstrate that there is no evidence showing that the program is not provider-operated*. The MAC shall review the evidence provided, and be satisfied that all provider-operated criteria at §413.85(f)(1) are met first, and only then shall the MAC approve pass-through payment to the hospital for the program. *MACs shall not rely on a degree/diploma/certificate issued by the hospital as evidence that a program is provider-operated*.

We have also received questions about the meaning of the parenthetical statement at §413.85(f)(1)(ii), which states "(A provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider must provide all of the courses relating to the theory and practice of the nursing or allied health profession involved that are required for the degree, diploma, or certificate awarded at the completion of the program.)" We are clarifying our existing policy below; we are not changing policy on this matter.

Regarding arrangements between hospitals and colleges or universities that could be acceptable, the January 12, 2001, *Federal Register* (66 FR 3363-4) states:

"…sequential operation of a nursing and allied health education program involves providers that enter into agreements with a college or university in which instruction in general academic requirements leading to a degree is provided by the educational institution and subsequent specialized didactic and clinical training is given by the provider. The provider may receive pass-through payment for the costs of the program that the provider incurs if the provider meets *all of the criteria for operating the program*, including the requirement at (§413.85(f)(1)(ii) of this final rule) that the *provider must directly control the curriculum*. We note that under this section of the regulations, there is a provision (also cited at § 413.85(f)(1)(v) of this final rule) which states that a provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but *the provider must provide all of the courses related to the theory and practice of the nursing or allied health profession involved that are required* for the degree, diploma, or certificate awarded at the completion of the program. No costs incurred by the college or university may be claimed as provider costs (emphasis added)."

That is, the hospital is always responsible for meeting the provider-operated criteria; hospital staff, not staff from an educational institution, must be responsible for controlling, managing, and operating the program financially and administratively on a daily basis, such as, but not limited to, enrollment, collection of tuition, human resources matters, and payroll. While §413.85(f)(1)(iii) states that a provider may contract with another entity to perform some administrative functions of day to day operations, the provider must maintain control over all aspects of the contracted functions. The hospital cannot have an arrangement with an educational institution where there are certain functions for which the hospital has no involvement and no oversight. If educational institution personnel are involved, hospital staff must have final decision making authority. In addition, the hospital may contract with an educational institution to provide basic courses required for a degree (e.g., English 101), but the hospital must teach all the courses related to the theory and practice of the particular nursing or allied health specialty.

The January 12, 2001, final rule provides additional guidance on what "direct control" of the curriculum means. Although the accrediting agency often dictates which courses and the order of the courses that must be completed by each student, to the extent where there is some flexibility provided by the accrediting body, it must be the hospital, not another educational institution deciding upon the order of the coursework, and the manner its students will accomplish the coursework that will allow the program to be accredited. In addition, there may be certain courses that are unique to the hospital, and the hospital decides what those courses are and when they are taught. Furthermore, control of the curriculum means the hospital actually provides all of the courses, or, with respect to the basic courses required for completion of the program (e.g., English 101), the hospital arranges for an outside organization to provide those academic courses necessary to complete the course work. (See 66 FR 3364).

II. Clarifications regarding payment for certain non-provider-operated programs

Sections 413.85(g)(1) and (2) specify that pass-through payment for the clinical costs (not classroom costs) of certain nonprovider-operated programs may be made to a hospital if, in part, the hospital claimed and was paid for clinical training costs on a reasonable cost basis during its most recent cost reporting period that ended on or before October 1, 1989. We note that section 4004(b) of Pub. L. 101-508 was intended to apply only to NAH programs which were not provider-operated in 1989, but for which hospitals erroneously claimed and received pass-through payment from Medicare in 1989. We emphasize that this provision allows the hospitals to receive pass-through payment after 1989 for the clinical costs of only those programs that were already not provider-operated in 1989; this provision is not intended to allow for the payment of the clinical costs of programs that became non-provider-operated after 1989. That is, after 1989, hospitals cannot receive pass-through payments under this provision for any other non-provider operated NAH program if the hospital did not receive pass-through payment in 1989. *Clinical training costs* are defined at §413.85(c) as "costs of training for the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the

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student upon graduation. Clinical training may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques; it involves no classroom instruction."

We have received questions about the proper way to determine the allowable clinical costs to be paid for the applicable nonprovider-operated programs. We are providing instructions to implement our existing policy below; we are not changing policy on this matter.

§413.85(g)(2)(iii) states:

In any cost reporting period, the percentage of total allowable provider cost attributable to allowable clinical training cost does not exceed the percentage of total cost for clinical training in the provider's most recent cost reporting period ending on or before October 1, 1989.

To determine whether the limit described in § 413.85(g)(2)(iii) applies to any non-provider operated program claimed in the current cost report and, if so, to compute the appropriate payment for such program or programs, the MAC shall:

1. Obtain the hospital's most recent cost report ending on or before October 1, 1989 (for ease of reference, we will refer to this cost report as the "1989" cost report).
2. For each current year's non-provider operated program, determine whether this same program was reported in the 1989 cost report (i.e., form HCFA-2552-89), worksheet A, line 20 and subscripts (nursing school(s)) and lines 23 and 24 and subscripts (Allied Health programs), column 7).It is important to ensure in this step that the 1989 NAH non-provider operated program is the same as the non-provider program in the current year. For example, the programs would not be the same in 1989 and the current year if the hospital reported a radiology technologist non-provider operated program and no other radiology-type programs in the 1989 cost report but in the current year' cost report the provider reported only a nuclear medicine technology non-provider operated program. As mentioned in the first paragraph of this section, the hospital is not entitled to receive pass-through payment in the current year for the nuclear medicine technology program because this program does not meet the requirements of § 413.85(g)(2) .
3. For each non-provider operated program found to have been reported in both the current and the 1989 cost reports in step 2, determine whether the program was not operated by the hospital in 1989 but the hospital received pass-through payment for it in that year.(See § 413.85(g)(2))ii).)
4. Only for each non-provider operated NAH program reported on worksheet A, line 20 and subscripts and line 23 and subscripts of the current cost report for which the hospital received pass-through payment in 1989 (as determined in step 3), compute the "1989 percentage" using steps 5 through 7 and the "current year percentage" using steps 8 through 10. Do not complete steps 5 through 11 for any current year's non-provider operated NAH programs if the hospital did not receive pass-through payments for the program(s) in 1989 (see step 3). 1989 percentage computation if required by step 4.
5. Numerator - for each program individually, from form HCFA-2552-89, determine the sum of the costs on lines 20 and 23, 24 and subscripts as applicable, column 7, of worksheet A.
6. Denominator - determine total allowable hospital costs from the amount on form HCFA-2552-89, worksheet A, line 95 subtotals, column 7. (We note that worksheet A, line 95 of the 1989 cost report contains only the "allowable" total provider cost since the non-reimbursable cost centers' costs are not included on this line. Per § 413.85(g)(2)(iii), the "percentage" is "the percentage of total allowable cost…")
7. Percentage from 1989 - for each program individually, divide the NAH cost amount from step 5 by the total allowable hospital cost from step 6. In accordance with *Provider Reimbursement Manual*-2 (PRM-2), Section 4000.1, percentages are rounded to two decimal places. Current year percentage
8. Using the current year cost report under review, only for programs that were nonprovider-operated in 1989 and are still nonprovider-operated in step 3, refer to form CMS-2552-10, worksheet A, line 20 (nursing school) and line 23 and subscripts (paramedical education programs as applicable), column 7. Numerator – for each program individually, use the amounts from worksheet A, lines 20 and subscripts and 23 and subscripts, column 7. For each program individually, verify that the amount on worksheet A, line 20 or its subscripts and/or line 23 or its subscripts, column 7 relate only to the "clinical costs" of the NAH program. If so, use the amount from this specific line. If the amount in column 7 for any of the programs contains "clinical training cost and classroom costs", subtract the "classroom costs" and use the net amount. (We note that for cost reporting periods beginning on or after October 1, 1990, PRM-2, Section 3610 (form CMSA-2552-96) and Section 4013 (form CMS-2552-10), specify that "classroom costs" related to non-provider operated NAH programs under § 413.85(g)(2) are not to be reported on lines 20, 24 (form CMS-2552-96) and 23 (form CMS-2552-10).)
9. Denominator - determine total allowable hospital costs from the amount on form CMS-2552-10, worksheet A, line 118 subtotals, column 7. (We note that worksheet A, line 118 of the current cost report contains only the "allowable" total provider cost since the non-reimbursable cost centers' costs are not included on this line. Per § 413.85(g)(2)(iii), the "percentage" is "the percentage of total allowable cost…").
10. Clinical percentage from the current cost report – for each program individually, divide the NAH clinical cost

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August is for continued education on IBT for obesity

Intensive behavioral therapy (IBT) for obesity

The A/B Medicare Administrative Contractor (MAC) Provider Outreach and Education (POE) Collaboration Team is recognizing the month of August for continued education on IBT for obesity. This focus can heighten awareness for preventable health problems that arise from obesity and provide patients with the necessary tools and training to lower these risks by addressing their obesity.

Did you know?

The size of Americans is a significant and valid concern for everyone, as the health risks related to obesity are substantially higher. Currently, obesity-related diabetes represents the most costly disease to the health care system.

To assist with this growing problem, Medicare provides coverage of **intensive behavioral therapy for obesity** for qualifying beneficiaries whose body mass index (BMI) is equal to or greater than 30 kg/m2.

Coverage includes:

- Screening for obesity in adults using measurement of BMI
- A dietary (nutritional) assessment
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions using diet and exercise

The frequency limitations include:

- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months two through six
- One face-to-face visit every month for months seven through 12, if the beneficiary meets the 3 kg (6.6 lbs.) weight loss requirement during the first six months.

How can you help?

Encourage your Medicare patients to take advantage of the intensive behavior therapy for obesity:

- *National coverage determination (NCD) 210.12 -- Intensive Behavioral Therapy Obesity*
- *CMS Preventive Service Tool*

This document was developed through the A/B Medicare Administrative Contractor (MAC) Provider Outreach & Education (POE) Collaboration Team. This joint effort ensures consistent communication and education throughout the nation on a variety of topics and will assist the provider and physician community with information necessary to submit claims appropriately and receive proper payment in a timely manner.

Source: POE A/B MAC Collaboration Team

Provider enrollment requirements for writing prescriptions for Medicare Part D drugs

***Note**: This article was rescinded August 2, 2018. This information was previously published in the December 2016 Medicare A Connection, pages 17-20.*

MLN Matters® Number: SE1434 *Rescinded*
Related CR Release Date: August 2, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A

Implementation N/A

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amount from step 8 by the total allowable hospital cost from step 9.In accordance with *PRM-2*, Section 4000.1, percentages are rounded to two decimal places.

11. For each program individually, compare the 1989 percentage (step 7) to the clinical percentage from the current cost report (step 10).If for any program, the current year percentage is greater than the 1989 year percentage, do not use the current year percentage; compute the current year's allowable clinical pass-through payment for the program by using the 1989 percentage. Proceed to pay the Medicare pass-through to the hospital in the current year for the clinical costs. For example, if the 1989 clinical percent was 30 percent, and the current year percent is 40 percent, only 30 percent of the hospital's current year clinical costs are allowable for Medicare pass-through payment. If for any program, the current year percentage is equal to or less than the 1989 percentage, then 100 percent of the hospital's current year clinical costs are allowable for Medicare pass-through payment; use the current year percentage.

Change Request 10552
Effective date: August 17, 2018
Implementation date: November 19, 2018

Hurricane Maria and Medicare disaster-related U.S. Virgin Islands and Puerto Rico claims

Note: This article was revised July 25, 2018, to advise providers that the public health emergency (PHE) declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico expired June 13, 2018. All other information is unchanged. This information was previously published in the *October 2017 Medicare A Connection, page 7-10*.

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands and the Commonwealth of Puerto Rico who were affected by Hurricane Maria.

Provider information available

On September 18, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Maria, an emergency exists in the United States Virgin Islands and the Commonwealth of Puerto Rico. Also on September 19, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the United States Virgin Islands and the Commonwealth of Puerto Rico and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 16, 2017, for the United States Virgin Islands and retroactive to September 17, 2017, for the Commonwealth of Puerto Rico. The PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed on December 15, 2017, renewed again on March 15, 2018, and renewed again on June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico were extended to March 15, 2018, and were extended again March 16, 2018, to June 13, 2018. **The PHE and Section 1135 waiver authority for Puerto Rico expired June 13, 2018**

On September 19, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands and the Commonwealth of Puerto Rico, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted geographical areas of the United States Virgin Islands and the Commonwealth of Puerto Rico. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

The most current waiver information can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html*. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

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

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands from September 16, 2017, and the Commonwealth of Puerto Rico from September 17, 2017, for the duration of the emergency. In accordance with CR 6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. The most current information can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html*. Medicare FFS Questions & Answers (Q&As) posted on that web page and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands and the Commonwealth of Puerto Rico. These Q&As are displayed in two files:
   - One file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands and the Commonwealth of Puerto Rico.
   - Another file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 16, 2017, for the United States Virgin Islands and September 17, 2017, for the Commonwealth of Puerto Rico.

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

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

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

Blanket waivers issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **the United States Virgin Islands and Commonwealth of Puerto Rico**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Maria in the United States Virgin Islands and the Commonwealth of Puerto Rico in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
- 42 CFR 483.20: Waiver provides relief to Skilled Nursing Facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission. (Blanket waiver for all impacted agencies)

Critical access hospitals

This action waives the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Maria, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to Hurricane Maria. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Maria, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of Hurricane Maria, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

Emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Maria, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

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For more information refer to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Appeal administrative relief for areas affected by Hurricane Maria

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

Replacement prescription fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria – This information added October 2, 2017.

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs to inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, renal dialysis facilities, and ambulatory surgical centers located in areas affected by Hurricane Maria due to the devastating impact of the storm. These providers will be granted exceptions without having to submit an Extraordinary Circumstances Exceptions (ECE) request if they are located in one of the 78 Puerto Rico municipios or one of the three U.S. Virgin Islands county-equivalents, all of which have been designated by the *Federal Emergency Management Agency (FEMA)* as a major disaster municipio or county-equivalent.

The scope and duration of the exception under each Medicare quality reporting program is described in the memorandum that CMS posted *September 25, 2017*, however, all of the exceptions are being granted to assist these providers while they direct their resources toward caring for their patients and repairing structural damages to facilities.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional information

If you have questions, your MACs may have more information. Find their website at *https://go.cms.gov/MAC-website-list*.

The Centers for Disease Control and Prevention released *ICD-10-CM coding advice* to report healthcare encounters in the hurricane aftermath.

Providers may also want to review the CMS Emergency and Preparedness webpage at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home.html*.

Providers may also want to view the Survey and Certification Frequently Asked Questions at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
July 25, 2018	This article was revised to advise providers that the PHE declaration and Section 1135 waiver authority for the U.S. Virgin Islands were renewed again June 13, 2018. The PHE and Section 1135 waiver authority for Puerto Rico expired June 13, 2018. The article was updated October 2, 2017, to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same.
October 2, 2017	The article was updated October 2, 2017, to include the section 'Applicability of reporting requirements for inpatient psychiatric facilities, skilled nursing facilities, home health agencies, hospices, inpatient rehabilitation facilities, ambulatory surgical centers, and renal dialysis facilities affected by Hurricane Maria.' All other information remains the same.
September 21, 2017	Initial article released.

MLN Matters® Number: SE17028 *Revised*
Related CR Release Date: July 25, 2018
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage web page at *https://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the First Coast eNews mailing list. Simply go to *https://medicare.fcso.com/Header/137525.asp*, enter your email address and select the subscription option that best meets your needs.

More information

For more information, or, if you do not have internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? First Coast's LCD lookup, available at *https://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp*, helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

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

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

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

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

Search capability simplifies LCD lookup

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

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

Click here for more information.

Retired LCDs

Leucovorin (Wellcovorin®) – retired Part A and Part B LCD

LCD ID number: L34012 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for leucovorin (Wellcovorin®), 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 August 3, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Psychiatric diagnostic evaluation and psychotherapy services – retired Part A and Part B "coding guidelines"

LCD ID number: L33252 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD), it was determined that the "Coding guideline" attachment is no longer required and, therefore, is being retired.

Effective date

The retirement of this LCD "Coding Guideline" attachment is effective for services rendered **on or after August 7, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Revisions to LCDs

Electroretinography (ERG) – revision to the Part A and Part B LCD

LCD ID number: L37398 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request of the Electroretinography (ERG) local coverage determination (LCD), the "Bibliography" section of the LCD was updated to add multiple published sources. The content of the LCD has not been changed in response to the reconsideration request.

Effective date

This revision to the LCD is effective for services rendered **on or after August 7, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Erythropoiesis stimulating agents – revision to the Part A and Part B LCD

LCD ID number: L36276 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change requests (CRs) 10624, 10699, 10781, 10788, and 10818 (July 2018 Quarterly Update) and a reconsideration request, the local coverage determination (LCD) for erythropoiesis stimulating agents was revised to add Healthcare Common Procedure Coding System (HCPCS) codes Q5105 and Q5106 to the "CPT®/HCPCS Codes" section of the LCD for Part A and Part B. Also, HCPCS code Q5106 was added to "Group 3 and 4 Paragraph" and HCPCS code Q5105 was added to "Group 5 Paragraph" in the "ICD-10 Codes that Support Medical Necessity" section of the LCD. In addition, the "Sources of information" section of the LCD was updated.

Furthermore, the LCD was revised to ensure quoted italicized language is current with the language in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manuals (IOM) referenced in the LCD.

Effective date

The LCD revision related to the July 2018 quarterly update is effective for services rendered **on or after July 1, 2018.**

The LCD revision related to quoted italicized language is based on process date.

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*.

Mohs micrographic surgery (MMS) – revision to the Part A and Part B LCD

LCD ID number: L33689 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for Mohs micrographic surgery (MMS), it was determined that some of the italicized language in the "Limitations" section of the LCD does not represent direct quotation from a Centers for Medicare & Medicaid Services (CMS) source listed in the LCD. Therefore, this LCD is being revised to assure consistency with the CMS source.

Effective date

The LCD revision is effective for services rendered **on or after August 7, 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 LCD page.

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

Non-invasive extracranial arterial studies – revision to the Part A and Part B LCD

LCD ID number: L33695 (Florida, Puerto Rico/ U.S. Virgin Islands)

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

Effective date

This LCD revision is effective for services rendered **on or after August 7, 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*.

Update to Chapter 11 of the 'Medicare Benefit Policy Manual'

Provider type affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME/MACs) and A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10809 which informs MACs about an update to the *Medicare Benefit Policy Manual*, Chapter 11, Section 100, extending renal dialysis services paid under Section 1881(b)(14) of the Social Security Act to beneficiaries with acute kidney injury (AKI), effective January 1, 2017. This revision does not represent a policy change. Specifically, the manual has been updated to state that erythropoietin stimulating agents (ESAs) are included in the bundled payment amount for treatments administered to patients with AKI. The non-ESRD HCPCS codes should be used (J0881, J0883, J0885, J0888, Q0138). The revenue codes for reporting Epoetin Alfa are 0634 and 0635. All other ESAs are reported using revenue code 0636.

Make sure your billing staffs are aware of these changes.

Background

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

Additional information

The official instruction, CR 10809, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R244BP.pdf*.

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
July 20, 2018	Initial article released.

MLN Matters® Number: MM10809
Related CR Release Date: July 20, 2018
Related CR Transmittal Number: R244BP
Related Change Request (CR) Number: 10809
Effective Date: October 23, 2018
Implementation October 23, 2018

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

October update to the 2018 Medicare physician fee schedule database

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) 10898 amends payment files issued to MACs based upon the 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 MPFS final rule, published in the *Federal Register* November 15, 2017, to be effective for services furnished from January 1, 2018, through December 31, 2018.

CR 10898 presents a summary of the changes for the October update to the 2018 MPFS. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative value units (RVU) for physicians' services. Unless otherwise stated, these changes are effective for dates of service on and after January 1, 2018.

The HCPCS codes listed below have been added to the Medicare physician fee schedule database (MPFSDB) effective for dates of service on and after October 1, 2018.

HCPCS	Action
G9978	Non-facility & facility PE RVU = 0.23. All other MPFS indicators & RVUs = 99201
G9979	Non-facility & facility PE RVU = 0.42. All other MPFS indicators & RVUs = 99202
G9980	Non-facility & facility PE RVU = 0.60. All other MPFS indicators & RVUs = 99203
G9981	Non-facility & facility PE RVU = 1.01. All other MPFS indicators & RVUs = 99204
G9982	Non-facility & facility PE RVU = 1.32. All other MPFS indicators & RVUs = 99205
G9983	Non-facility & facility PE RVU = 0.20. All other MPFS indicators & RVUs = 99212
G9984	Non-facility & facility PE RVU = 0.41. All other MPFS indicators & RVUs = 99213
G9985	Non-facility & facility PE RVU = 0.62. All other MPFS indicators & RVUs = 99214
G9986	Non-facility & facility PE RVU = 0.88. All other MPFS indicators & RVUs = 99215
G9987	Non-facility & facility PE RVU = 1.06. All other MPFS indicators & RVUs = G9187

The following "Q" codes are effective on or after July 1, 2018 (see CR 10626 for additional information on HCPCS code Q9994 and CR 10624 on HCPCS codes Q5105 and Q5106). HCPCS code Q5108 is effective July 12, 2018. See CR 10834 for more information on HCPCS Q5108:

Code	Action
Q9994	Procedure status = X; there are no RVUs, payment policy indicators do not apply.
Q5105	Procedure status = E; there are no RVUs, payment policy indicators do not apply.
Q5106	Procedure status = E; there are no RVUs, payment policy indicators do not apply.
Q5108	Procedure status = E; there are no RVUs, payment policy indicators do not apply.

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.

Additional information

The official instruction, CR 10898, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4109CP.pdf*.

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
August 10, 2018	Initial article released.

MLN Matters® Number: MM10898
Related CR Release Date: August 10, 2018
Related CR Transmittal Number: R4109CP
Related Change Request (CR) Number: 10898
Effective Date: January 1, 2018
Implementation October 1, 2018

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

Provider type affected

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

Provider action needed

Change request (CR) 10875 provides instructions for the quarterly update to the clinical laboratory fee schedule (CLFS). These updates apply to Chapter 16, Section 20 of the *Medicare Claims Processing Manual*. Please make sure your billing staffs are aware of these updates.

Background

Effective January 1, 2018, CLFS rates will be based on weighted median private payer rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, the PAMA regulations are available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*.

Note: Part B deductible and coinsurance do not apply for services paid under the CLFS.

Access to data file

Internet access to the quarterly CLFS data file will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Other interested parties, such as the Medicare state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, will use the internet to retrieve the quarterly CLFS. It will be available in Excel, text, and comma delimited formats.

Pricing information

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

New codes

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

These new codes are effective July 1, 2018

- 0045U TOS 5; short descriptor—ONC BRST DUX CARC IS 12 GENE; long descriptor—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
- 0046U TOS 5; short descriptor—FLT3 GENE ITD VARIANTS QUAN; long descriptor—FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative
- 0047U TOS 5; short descriptor—ONC PRST8 MRNA 17 GENE ALG; long descriptor—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
- 0048U TOS 5; Short descriptor—ONC SLD ORG NEO DNA 468 GENE; Long descriptor—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 paraffin-embedded tumor tissue, report of clinically significant mutation(s)
- 0049U TOS 5; short descriptor—NPM1 GENE ANALYSIS QUAN; long descriptor—NPM1 (nucleophosmin) (e.g., acute myeloid leukemia) gene analysis, quantitative
- 0050U TOS 5; short descriptor—TRGT GEN SEQ DNA 194 GENES; long descriptor—Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements
- 0051U TOS 5; short descriptor—RX MNTR LC-MS/MS UR 31 PNL; long descriptor—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
- 0052U TOS 5; short descriptor—LPOPRTN BLD W/5 MAJ CLASSES; long descriptor—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
- 0053U TOS 5; short descriptor—ONC PRST8 CA FISH ALYS 4 GEN; long descriptor—Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade
- 0054U TOS 5; Short descriptor—RX MNTR 14+ DRUGS & SBSTS; Long descriptor—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

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CLFS

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- 0055U TOS 5; short descriptor—CARD HRT TRNSPL 96 DNA SEQ; long descriptor—Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma
- 0056U TOS 5; Short descriptor—HEM AML DNA GENE REARGMT; Long descriptor—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)
- 0057U TOS 5; short descriptor—ONC SLD ORG NEO MRNA 51 GENE; long descriptor—Oncology (solid organ neoplasia), mRNA, gene expression profiling by massively parallel sequencing for analysis of 51 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a normalized percentile rank
- 0058U TOS 5; short descriptor—ONC MERKEL CLL CARC SRM QUAN; long descriptor—Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus oncoprotein (small T antigen), serum, quantitative
- 0059U TOS 5; short descriptor— ONC MERKEL CLL CARC SRM +/-; long descriptor—Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus capsid protein (VP1), serum, reported as positive or negative
- 0060U TOS 5; short descriptor—TWN ZYG GEN SEQ ALYS CHRMS2; long descriptor—Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal blood
- 0061U TOS 5; short descriptor—TC MEAS 5 BMRK SFDI M-S ALYS; long descriptor—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)

This following existing code is revised, effective July 1, 2018:

- 0006U TOS 5; short descriptor—DETC IA MEDS 120+ ANALYTES; long descriptor—Detection of interacting medications, substances, supplements and foods, 120 or more analytes, definitive chromatography with mass spectrometry, urine, description and severity of each interaction identified per date of service

This following existing code is approved as an Advanced Diagnostic Laboratory Test (ADLT) and was added to the

CLFS effective July 1, 2018:

- 0037U TOS 5; short descriptor—Trgt gen seq dna 324 genes; long descriptor—Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden

Note: MACs will not search their files to either retract payment or retroactively pay claims. However, MACs should adjust claims if they are brought to their attention.

Additional information

The official instruction, CR 10875, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4090CP.pdf*.

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
July 20, 2018	Initial article released.

MLN Matters® Number: MM10875
Related CR Release Date: July 20, 2018
Related CR Transmittal Number: R4090CP
Related Change Request (CR) Number: 10875
Effective Date: October 1, 2018
Implementation October 1, 2018

October changes to the laboratory NCD edit software

Provider type affected

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

Provider action needed

This article is based on change request (CR) 10873 which informs MACs about the changes that will be included in the October 2018 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

Background

CR 10873 announces the changes that will be included in the October 2018 quarterly release of the edit module for clinical diagnostic laboratory services. The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Pub 100-03, Sections 190.12-190.34) were processed uniformly throughout the nation, effective April 1, 2003.

In accordance with Chapter 16, Section 120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.

CR 10873 communicates requirements to shared system maintainers (SSMs) and contractors, notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for October 2018. Please access the link below for the NCD spreadsheet of changes included with CR 10873: *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/October2018.zip*

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

Additional information

The official instruction, CR 10873, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4092CP.pdf*.

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
July 20, 2018	Initial article released.

MLN Matters® Number: MM10873
Related CR Release Date: July 20, 2018
Related CR Transmittal Number: R4092CP
Related Change Request (CR) Number: 10873
Effective Date: October 1, 2018
Implementation October 1, 2018

VACCINE

from page 1

- Home health agencies (34x)
- Hospital-based renal dialysis facilities (72x)
- Critical access hospitals (85x)

MACs will pay for influenza virus vaccine code 90689 with a TOS of V based on the lower of the actual charge or 95 percent of the average wholesale price (AWP), to:

- Indian service hospitals (IHS) (12x and 13x)
- Hospices (81x and 82x)
- IHS critical access hospitals (85x)
- Comprehensive outpatient rehabilitation facilities (CORFs) (75x)
- Independent renal dialysis facilities (72x)

Note: In all cases, coinsurance and deductible do not apply.

Additional information

The official instruction, CR 10871, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4100CP.pdf*.

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
August 6, 2018	Initial article released.

MLN Matters® Number: MM10871
Related CR Release Date: August 3, 2018
Related CR Transmittal Number: R4100CP
Related Change Request (CR) Number: 10871
Effective Date: January 1, 2019
Implementation January 7, 2019

Update to 2018 HCPCS codes used for SNF consolidated billing enforcement

Provider type affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare administrative contractors (MACs), including durable medical equipment MACs (DME MACs) for services provided in a skilled nursing facility (SNF) to Medicare beneficiaries.

Provider action needed

Change request (CR) 10852 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing (CB) provision of the SNF prospective payment system (PPS). Changes to *Current Procedural Terminology* (CPT®)/HCPCS codes and Medicare physician fee schedule designations are to revise common working file (CWF) edits to allow MACs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manual*, Chapter 6, Section 20.6. Make sure your billing staffs are aware of these changes.

Background

CR 10852 alerts providers that the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS. services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to MACs, including DME MACs, will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

The updated lists for institutional and professional billing are available at *https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*. Certain codes are included as services that are not subject to SNF CB. You may submit these codes globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC).

Certain codes are included as services that are not subject to SNF CB. These codes can be submitted globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC). When the codes listed below are submitted globally or just for the technical component, the claims submitted to the MACs (Part B) are being rejected by the CWF. That is to say, they are not allowed to pay separately outside of the consolidated payment that is made to the SNF. When submitted with the 26 modifier for just the professional component, the claims have been allowed to pay. The codes are:

- Codes that should have been added effective January 1, 2016 - 77770, 77771, 77772
- Codes that should have been added effective January 1, 2017 - G0491, G0500, J9034, J9301, Q0083, Q0084, Q0085, 36598, 77385, 77386, 77770, 77771, 77772, 79005, 79101, 79445, 96446, 99151, 99152, 99155, 99156, and 99157
- Codes that should have been added effective January 1, 2018 - 00731, 00732, 00811, 00812, 00813, and 77772

The above errors are occurring because CMS did not add the codes to the appropriate coding lists with the 2016, 2017, and 2018 SNF CB Annual Updates. Therefore, for claims with dates of service on or after January 1, 2016, the MACs (Part B) will re-open and reprocess impacted claims, if you bring those claims to the attention of your MAC. MACs (Part B) will notify providers that if they have already received payment for these services from the SNF, they need to return that payment to the SNF in order to receive payment from Medicare. Providers may not be paid twice for the same service and such a request could be construed as a fraudulent claim.

The following HCPCS will be added to Major Category 1 (Exclusion of Services Beyond the Scope of a SNF) exclusions retroactive to July 1, 2018:

- Q5105 Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units
- Q5106 Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units

For claims processed on or after October 1, 2018, HCPCS codes Q5105 and Q5106 will be added to physician services for SNF consolidated billing with an effective date of July 1, 2018.

Note: MACs will re-open and re-process the claims brought to their attention, for claims with dates of service on or after July 1, 2018, that have previously been denied/rejected prior to the implementation of CR 10852.

Additional information

The official instruction, CR 10852, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4093CP.pdf*.

If you have questions, Find your MACs website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
July 20, 2018	Initial article released.

MLN Matters® Number: MM10852
Related CR Release Date: July 20, 2018
Related CR Transmittal Number: R4093CP
Related Change Request (CR) Number: 10852
Effective Date: January 1, 2016
Implementation October 1, 2018

July 2018 update of drug and biological code changes

***Note**: This article was revised July 6, 2018, to reflect a revised CR issued July 5. The article is revised to show the type of service code for CPT® code 90739 remains as V. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same. This information was previously published in the July 2018 Medicare A Connection, page 21.*

Provider type affected

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

Provider action needed

CR 10624 informs MACs of updated drug/biological HCPCS codes. The HCPCS code set is updated on a quarterly basis. The July 2018 HCPCS file includes six new HCPCS codes: Q9991, Q9992, Q9993, Q9995, Q5105, and Q5106. Please make sure your billing staffs are aware of these updates.

Background

The July 2018 HCPCS file includes six new HCPCS codes, which are payable by Medicare, effective for claims with dates of service on or after July 1, 2018. Part B payment for HCPCS code Q9995 will include the clotting factor furnishing fee. These codes are:

- **Q9991**
  - Short description: Buprenorph xr 100 mg or less
  - Long description: Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg
  - Type of service (TOS) code: 1
  - Medicare physician fee schedule data base (MPFSDB) status indicator: E
- **Q9992**
  - Short description: Buprenorphine xr over 100 mg
  - Long description: Injection, buprenorphine extended-release (sublocade), greater than 100 mg
  - TOS code: 1
  - MPFSDB status indicator: E
- **Q9993**
  - Short description: Inj., triamcinolone ext rel
  - Long description: Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg
  - TOS code: 1,P
  - MPFSDB status indicator: E
- **Q9995**
  - Short description: Inj. emicizumab-kxwh, 0.5 mg
  - Long description: Injection, emicizumab-kxwh, 0.5 mg
  - TOS code: 1
  - MPFSDB status indicator: E
- **Q5105**
  - Short description: Inj Retacrit esrd on dialysis
  - Long description: Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units
  - TOS code: 1, L
  - MPFSDB status indicator: E
- **Q5106**
  - Short description: Inj Retacrit non-esrd use
  - Long description: Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units
  - TOS code: 9
  - MPFSDB status indicator: E

In addition to the new codes, the TOS code for CPT® code 90739 remains as V.

Additional information

The official instruction, CR 10624, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4083CP.pdf*.

If you have questions, your MACs website at *https://go.cms.gov/MAC-website-list*.

Document history

Date of change	Description
July 6, 2018	The article was revised to reflect a revised CR issued July 5. The article is revised to show the type of service code for CPT® code 90739 remains as V. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.
June 26, 2018	The article was revised to reflect a revised CR issued June 26. In the article, the new codes of Q5105 and Q5106 are added. The type of service code for CPT® code 90739 is updated to 1, V. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.
May 14, 2018	This article was revised to reflect a revised CR issued May 11. In the article, a sentence is added to show that Part B payment for Q9995 includes the clotting factor furnishing fee. Also, the CR release date, transmittal number, and the web address of the CR are revised. All other information is the same.
April 20, 2018	Initial article released.

MLN Matters® Number: MM10624 *Revised*
Related CR Release Date: July 5, 2018
Related CR Transmittal Number: R4083CP
Related Change Request (CR) Number: 10624
Effective Date: July 1, 2018
Implementation July 2, 2018

User CR: FISS to add additional search features to provider direct data entry screen

Provider type affected

MLN Matters® article 10542 is a one-time notice that highlights the improved claim search capability in fiscal intermediary shared system (FISS) for providers who use direct data entry screen (DDE) and submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10542 allows providers who use DDE to look up the claims associated with an accounts receivable (AR) by using the invoice number on the AR to find the document control number (DCN), and then using the DCN to look up the claims. This update will improve provider customer service, allowing providers to find the claim associated with the AR and reconcile it back to their patient accounts. Please make certain your billing staff is aware of this enhancement. Detailed instructions on how to use the new feature will be provided closer to implementation.

Background

CR 10542 gives providers the ability to find the claims associated with a receivable through DDE screens. Providers will use a new look up feature in DDE to use the invoice number on the receivable to find the DCN. Then, they can use the DCN to find the associated claims.

Additional information

The official instruction, CR 10542, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2112OTN.pdf*.

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
August 14, 2018	Initial article released.

MLN Matters® Number: MM10542
Related CR Release Date: August 10, 2018
Related CR Transmittal Number: R2112OTN
Related Change Request (CR) Number: 10542
Effective Date: January 1, 2019
Implementation January 7, 2019

Find out first: Subscribe to First Coast *eNews*

Subscribe to First Coast Service Options *eNews*, to learn the latest Medicare news and critical program changes affecting the provider community. Join as many lists as you wish, in English or Spanish, and customize your subscription to fit your specific needs, line of business, specialty, or topics of interest. So, *subscribe to eNews, and stay informed.*

Upcoming provider outreach and educational events

Topic: Home health referrals and clinical documentation requirements

Date: Tuesday, September 11
Time: 11:00 a.m.-noon
Type of Event: Webcast

https://medicare.fcso.com/Events/0413410.asp

Topic: Medicare Part A changes and regulations

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

https://medicare.fcso.com/Events/0412160.asp

Note: Unless otherwise indicated, designated times for educational events are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at *https://gm1.geolearning.com/geonext/fcso/opensite.geo*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

MLN Connects®

CMS MLN Connects®

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects®* is an official *Medicare Learning Network®* (*MLN*) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the *MLN Connects®* to its membership as appropriate.

MLN Connects® – Special Edition for July 23, 2018

New Medicare Card Mailing Update – Wave 4 Begins, Wave 2 Ends

CMS started mailing new Medicare cards to people with Medicare who live in Wave 4 states: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, and Vermont. We continue to mail new cards to people who live in Wave 3 states, as well as nationwide to people who are new to Medicare.

We finished mailing cards to people with Medicare who live in Wave 1 and Wave 2 states and territories (Alaska, American Samoa, California, Delaware, District of Columbia, Guam, Hawaii, Maryland, Northern Mariana Islands, Pennsylvania, Oregon, Virginia, and West Virginia). If someone with Medicare says they did not get a card, print and give them the "Still Waiting for Your New Card?" handout (in *English* or *Spanish*) or instruct them to:

Sign into *MyMedicare.gov* to see if we mailed their card. If so, they can print an official card. They need to create an account if they do not already have one

Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

To ensure that people with Medicare continue to get care, health care providers and suppliers can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check the *mailing strategy* as the mailings progress. Continue to direct people with Medicare to *Medicare.gov/NewCard* for information about the mailings and to sign up to get email about the status of card mailings in their state.

We are committed to mailing new cards to all people with Medicare by April 2019.

Information on the transition to the new MBI:

- *New MBI Get It, Use It* MLN Matters® Article (Updated7/11/18)
- *Transition to New Medicare Numbers and Cards* MLN Fact Sheet
- *New Medicare Card information* website

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MLN Connects® – Special Edition for July 25, 2018

CMS Empowers Patients and Ensures Site-Neutral Payment in Proposed Rule

Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) proposed rule advances CMS commitment to increasing transparency and lowering drug prices

On July 25, CMS took steps to strengthen the Medicare program with proposed changes to ensure that seniors can access the care they need at the site of care that they choose. In addition, as part of the agency's ongoing efforts to lower drug prices as outlined in the President's Blueprint, CMS included a Request for Information on how best to develop a model leveraging authority provided to the agency under the Competitive Acquisition Program (CAP) to strengthen negotiations for prescription drugs.

"Our healthcare system should always put patients first, and CMS today is taking important steps to empower patients and provide more affordable choices and options," said CMS Administrator Seema Verma. "In line with President Trump and Secretary Azar's priority to lower drug prices, today's proposed rule is also an important step towards expanding competition for drug payment in Medicare, in order to get the best deal for patients."

The proposed policies in the CY 2019 Medicare Hospital OPPS and ASC Payment System proposed rule would help lay the foundation for a patient-driven healthcare system. To increase the sustainability of the Medicare program and improve quality of care for seniors, CMS is moving toward site neutral payments for clinic visits (which are essentially check-ups with a clinician). Clinic visits are the most common service billed under the OPPS. Currently, CMS often pays more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting.

If finalized, this proposal is projected to save patients about $150 million in lower copayments for clinic visits provided at an off-campus hospital outpatient department.

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CMS is also proposing to close a potential loophole through which providers are billing patients more for visits in hospital outpatient departments when they create new service lines.

Additionally, CMS is giving patients more options on where to obtain care, in order to improve access and convenience and ensure that CMS policies are not favoring any particular provider type from the start. The proposed rule aims to address other payment differences between sites of service, so that patients can choose the setting that best meets their needs among safe and clinically appropriate options. For 2019, CMS is proposing to:

- Expand the number of procedures payable at ASCs to include additional procedures that can safely be performed in that setting
- Ensure ASC payment for procedures involving certain high-cost devices parallels the payment amount provided to hospital outpatient departments for these devices
- Help ensure that ASCs remain competitive by stabilizing the differential between ASC payment rates and hospital outpatient department payment rates

As part of active efforts to reduce the cost of prescription drugs, CMS is issuing a Request for Information to solicit public comment on how best to leverage the authority provided under the CAP to get a better deal for beneficiaries as part of a CMS Innovation Center model. We believe a CAP-based model would allow CMS to introduce competition to Medicare Part B, the part of Medicare that pays for medicines that patients receive in a doctor's office. Currently, CMS pays the average sales price for these therapies plus an extra add-on payment. A CAP-based model would allow CMS to bring on vendors to negotiate payment amounts for Part B drugs, so that Medicare is no longer merely a price taker for these medicines. We are seeking public comment on how the vendors that CMS brings on could help the agency structure value-based payment arrangements with manufacturers, especially for high-cost products, so that seniors and taxpayers will know that medicines are working before they have to pay.

In 2018, CMS implemented a payment policy to help beneficiaries save on coinsurance on drugs that were administered at hospital outpatient departments and that were acquired through the 340B program—a program that allows hospitals to buy certain outpatient drugs at a lower cost. Due to CMS's policy change, Medicare beneficiaries are now benefiting from the discounts that 340B hospitals enjoy when they receive 340B-acquired drugs. In 2018 alone, beneficiaries are saving an estimated $320 million on out-of-pocket payments for these drugs. For 2019, CMS is expanding this policy by proposing to extend the 340B payment change to non-excepted off-campus departments of hospitals that are paid under the Physician Fee Schedule.

In response to recommendations from the President's Commission on Combatting Drug Addiction and the Opioid Crisis, CMS also is proposing to pay separately for certain non-opioid pain management drugs in ASCs; is seeking feedback on evidence to support that other non-opioid alternative treatments for acute or chronic pain warrant separate payment under the OPPS or ASC payment systems; and is proposing to eliminate questions regarding pain communication from the hospital patient experience survey.

As part of its commitment to price transparency, CMS is seeking comment through a Request for Information asking whether providers and suppliers can and should be required to inform patients about charge and payment information for healthcare services and out-of-pocket costs, what data elements would be most useful to promote price shopping, and what other changes are needed to empower healthcare consumers.

In the proposed rule, CMS is releasing a Request for Information to welcome continued feedback on the Medicare program and interoperability. CMS is gathering public feedback on revising the CMS patient health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers.

Across all the Fiscal Year and CY proposed Medicare payment rules, we have proposed the elimination of reporting requirements for over 100 measures across the health care delivery system, saving providers more than $175 million over the next two years.

See the full text of this excerpted *CMS Press Release* (issued July 25).

For More Information:

- *Proposed Rule*
- *Fact Sheet*

MLN Connects® for July 26, 2018

MLN Connects® for July 26, 2018
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News & Announcements

- New Medicare Card: Using Your MAC's MBI Look-Up Tool
- E/M Coding Reform: Recording of Panel Discussion
- Patients Over Paperwork July Newsletter
- Hospice Quality Reporting Program Quick Reference Guide
- HQRP Non-Compliance Letters: Request for Reconsideration by August 7
- IRF QRP Non-Compliance Letters: Request for Reconsideration by August 7
- LTCH QRP Non-Compliance Letters: Request for Reconsideration by August 7
- SNF QRP Non-Compliance Letters: Request for Reconsideration by August 7
- Emergency Preparedness: Information on Radiological Incidents, DME, and Blood
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

Provider Compliance

- Proper Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing

Upcoming Events

- MIPS Improvement Activities Performance Category Year 2 Overview Webinar — August 1
- MIPS Quality Performance Category Year 2 Overview Webinar — August 6
- ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14

Medicare Learning Network Publications & Multimedia

- IOM Update to Publication 100-02, Chapter 11 – ESRD MLN Matters Article — New
- New Waived Tests MLN Matters Article — New
- HCPCS Codes Used for SNF CB Enforcement: Annual Update MLN Matters Article — New
- Changes to the Laboratory NCD Edit Software: October 2018 MLN Matters Article — New
- CLFS and Laboratory Services Payment: Quarterly Update MLN Matters Article — New

MLN Connects® for August 2, 2018

MLN Connects® for August 2, 2018
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News & Announcements

- SNF FY 2019 Payment and Policy Changes
- IRF FY 2019 Prospective Payment System Final Rule
- IPF FY 2019 Final Medicare Payment and Quality Reporting Updates
- Qualified Medicare Beneficiary Program Billing Requirements FAQs
- Data Element Library Webinar: Video Recording
- CMS Administrator Address on Strengthening Medicare
- 2018 QRDA III Implementation Guide for Eligible Professionals — Updated
- LTCH Provider Preview Reports Reissued

Provider Compliance

- Ophthalmology Services: Questionable Billing and Improper Payments — Reminder

Upcoming Events

- MIPS Quality Performance Category for Year 2 (2018) Overview Webinar — August 6
- ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14
- Sharing Federal Strategies to Address the Opioid Epidemic Open Door Forum — August 15
- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session – August 22

Medicare Learning Network Publications & Multimedia

- Provider Minute Video: Physician Orders/Intent to Order Laboratory Services and Other Diagnostic Services - New
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder
- Medicare Enrollment Resources Educational Tool — Reminder
- PECOS for DMEPOS Suppliers Booklet — Reminder

MLN Connects® – Special Edition for August 2, 2018

Changes to Empower Patients and Reduce Administrative Burden

Changes in the IPPS and LTCH PPS final rule will advance price transparency and electronic health records

On August 2, CMS finalized a rule to empower patients and advance the White House *MyHealthEData* initiative and the CMS *Patients Over Paperwork* initiative. This final rule and others issued earlier this week will help improve access to hospital price information, give patients greater access to their health information and allow clinicians to spend more time with their patients.

Individually and collectively, these final rules put patients first, ease provider burden, and make significant strides in modernizing Medicare. The August 2 final rule makes updates to Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) that will incentivize value-based, quality care at these facilities. CMS also issued final rules this week on fiscal year (FY) 2019 Medicare payments and policies for the Skilled Nursing Facility (SNF) PPS, Inpatient Psychiatric Facility (IPF) PPS, Inpatient Rehabilitation Facility (IRF) PPS, and the Hospice Wage Index and Payment Rate Update.

"We're excited to make these changes to ensure care will focus on the patient, not on needless paperwork," said CMS Administrator Seema Verma. "We've listened to patients and their doctors who urged us to remove the obstacles getting in the way of quality care and positive health outcomes. Today's final rule reflects public feedback on CMS proposals issued in April, and the agency's patient-driven priorities of improving the quality and safety of care, advancing health information exchange and usability, and removing outdated or redundant regulations on healthcare providers to make way for innovation and greater value."

Along with policy changes, the FY 2019 IPPS/LTCH PPS final rule provides acute care hospitals an average payment increase of approximately 3 percent, which reflects rate updates required by law and payments for new technologies and uncompensated care.

The IPPS/LTCH PPS final rule also updates geographic payment adjustments for IPPS hospitals. CMS looks forward to continuing to work on geographic payment disparities, particularly for rural hospitals, to the extent permitted under current law and appreciates responses to our request for public input on this issue. By allowing the imputed wage index floor to expire for all-urban states, CMS has begun the process of making geographic payments more equitable for rural hospitals.

In addition, CMS is updating the LTCH PPS standard federal payment rate by 1.35 percent. Overall, under the changes included in the final rule, CMS projects that LTCH PPS payments will increase by approximately 0.9 percent, or $39 million in FY 2019. In addition, CMS is finalizing the proposal to eliminate the 25 percent threshold policy in a budget neutral manner.

MyHealthEData and Interoperability

The policies in the FY 2019 IPPS/LTCH PPS final rule will bring us closer to the agency's goal of creating a patient-centered healthcare system by increasing price transparency and fluid information exchange— essential components of value-based care —while also significantly lifting the administrative burden on hospitals so they can operate with greater flexibility and patients have the information they need to make decisions about their own care. CMS received stakeholder feedback on solutions for achieving interoperability, or the sharing of healthcare data between providers, through responses to a Request for Information (RFI) issued in April in the IPPS/LTCH PPS proposed rule.

While CMS previously required hospitals to make publicly available a list of their standard charges or their policies for allowing the public to view this list upon request, CMS has updated its guidelines to specifically require hospitals to post this information on the Internet in a machine-readable format. The agency is considering future actions based on the public feedback it received on ways hospitals can display price information that would be most useful to stakeholders and how to create patient-friendly interfaces that allow consumers to more easily access relevant healthcare data and compare providers.

The policies released on August 2 begin implementing core pieces of the White House-led *MyHealthEData* initiative through several steps to strengthen interoperability. In the IPPS/LTCH PPS final rule, CMS overhauls the Medicare and Medicaid Promoting Interoperability Programs (formerly known as the "Meaningful Use" program or Medicare and Medicaid Electronic Health Record Incentive Programs) to:

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

Meaningful Measures and Transparency

CMS's Meaningful Measures initiative is centered on patient safety, quality of care, transparency and ensuring that the measure sets providers are asked to report make the most sense. In the IPPS/LTCH PPS final rule, CMS is removing unnecessary, redundant and process-driven measures from several pay-for-reporting and pay-for-performance quality programs. The final rule eliminates a number of measures acute care hospitals are currently required to report across the four hospital pay-for-reporting

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and value-based purchasing quality programs. It also "de-duplicates" certain measures that are in multiple programs, keeping them in the program where they can best incentivize improvement and maintaining transparency through public reporting. In all, these changes will remove a total of 18 measures from the programs and de-duplicate another 25 measures while still ensuring meaningful measures of hospital quality and patient safety. In addition to the changes that apply to acute care hospitals, the final rule eliminates three measures in the LTCH Quality Reporting Program. Lastly, CMS is making a variety of other changes to reduce the hours providers spend on paperwork. This new flexibility will allow hospitals to spend more time providing care to their patients, thereby improving the quality of care their patients receive. Overall, changes in the hospital quality and value measures across the four programs will eliminate more than 2 million burden hours for hospitals impacted by the IPPS/LTCH PPS rule, saving them about $75 million annually after these changes are implemented.

Similarly, the SNF PPS, IPF PPS and IRF PPS final rules establish policies that ensure the measures those providers must report are patient-centered and outcome-driven rather than process-oriented. Where applicable, these changes will allow providers to work with a smaller set of more meaningful healthcare measures and spend more time on patient care.

CMS is also advancing Meaningful Measures through the Hospice Wage Index and Payment Rate Update. This final rule will make Hospice Compare public data easier and more efficient to use.

Patients Over Paperwork

The SNF PPS final rule incorporates the agency's Patients Over Paperwork initiative through avenues that reduce unnecessary burden on providers by easing documentation requirements and offering more flexibility. As part of the agency's actions to modernize Medicare, the SNF PPS rule establishes an innovative new classification system, the Patient Driven Payment Model (PDPM), which ties skilled nursing facility payments to patients' conditions and care needs rather than volume of services provided. The new model will better incentivize treating the needs of the whole patient, rather than focusing on the amount of services for that patient, which requires substantial paperwork to track over time. The PDPM approach advances CMS's efforts to build a patient-driven healthcare system starting with innovation throughout Medicare's payment systems. Under this new SNF payment model, patients will have more opportunity to choose a skilled nursing facility that offers services tailored to their condition and preferences, as the payment to these facilities will be based more on the patient's condition rather than the specific services each skilled nursing facility provides.

Modernizing Medicare in additional ways to benefit patients, the final IRF PPS rule adopts advances in telecommunications technology and removes obstacles that may prevent rehabilitation physicians from conducting certain meetings without being physically in the room. The rule also removes overly prescriptive documentation requirements for admission orders for these rehabilitation facilities.

Read the full text of this excerpted *Press Release* (issued August 2).

Final Rules:

- *IPPS/LTCH*
- *SNF*
- *IPF*
- *Hospice*
- *IRF*

Fact Sheets:

- *IPPS/LTCH*
- *SNF*
- *IPF*
- *Hospice*
- *IRF*

Where do I find...

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

MLN Connects® for August 9, 2018

MLN Connects® for August 9, 2018

View this edition as a PDF

News & Announcements

- Help Your Medicare Patients Avoid and Report Scams
- SNF VBP FY 2019 Annual Performance Score Report: Submit Correction Requests by August 31
- Quality Payment Program Exception Applications Due by December 31
- Quality Payment Program: 2017 MIPS Performance Feedback and Payment Adjustment
- Quality Payment Program Performance Feedback and Targeted Review Videos
- Medicare Diabetes Prevention Program Suppliers: Separate Medicare Enrollment
- Vaccines are Not Just for Kids

Provider Compliance

- Reporting Changes in Ownership — Reminder

Upcoming Events

- ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14
- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 22
- Comparative Billing Report on Licensed Clinical Social Workers Webinar — September 12

Medicare Learning Network Publications & Multimedia

- Quarterly Influenza Virus Vaccine Code Update: January 2019 MLN Matters Article — New
- Update to Medicare Claims Processing Manual, Chapter 24 MLN Matters Article — New
- IRF Annual Update: PPS Pricer Changes for FY 2019 MLN Matters Article — New
- Implementing Epoetin Alfa Biosimilar, Retacrit for ESRD/AKI Claims MLN Matters Article — New
- Medicare Claims Processing Manual, Chapter 24 Update: Form Letters — New
- IPF PPS Updates for FY 2019 MLN Matters Article — New
- ASP Medicare Part B Drug Pricing Files and Revisions: October 2018 MLN Matters Article — New
- August 2018 Catalog — Revised
- Medicare Preventive Services Educational Tool — Revised
- Medicare Enrollment for Providers Who Solely Order, Certify, or Prescribe Booklet — Revised
- Quality Payment Program Year 2 Overview Web-Based Training Course — Revised
- Quality Payment Program: MIPS Promoting Interoperability Performance Category Year 2 Web-Based Training Course — Revised
- Quality Payment Program MIPS Quality Performance Category Year 2 Web-Based Training Course — Revised
- Safeguard Your Identity and Privacy Using PECOS Booklet — Reminder
- PECOS FAQs Booklet — Reminder
- PECOS for Provider and Supplier Organizations Booklet — Reminder

Medicare Diabetes Prevention Program Suppliers: Separate Medicare Enrollment

For a claim to be valid under the *Medicare Diabetes Prevention Program (MDPP)*, you must have a separate Medicare enrollment as a MDPP supplier. If you are an approved MDPP supplier and you meet the MDPP supplier requirements and standards (including preliminary or full Centers for Disease Control and Prevention recognition), you can submit claims for *HCPCS G-codes* for your services. If you do not have a separate Medicare enrollment as a MDPP supplier and you submit a claim for MDPP services, your claim will be rejected.

MLN Connects® for August 16, 2018

MLN Connects® for August 16, 2018

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News & Announcements

- New Medicare Card: Order Handouts for Patients That Did Not Get Their New Cards
- Proposed Pathways to Success for the Medicare Shared Savings Program
- Quality Payment Program: Design Examples for CY 2019 Proposed Rule
- Quality Payment Program: Participation Status Tool Includes 2018 Data Snapshot

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

Upcoming Events

- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 22

Medicare Learning Network Publications & Multimedia

- Inclusion of PMD Codes in DMEPOS Prior Authorization Program MLN Matters® Article — New
- Medicare Physician Fee Schedule Database: October 2018 Update MLN Matters Article — New
- Hospice Payment Rates, Cap, Wage Index, and Pricer: FY 2019 Update MLN Matters Article — New
- HCPCS Drug/Biological Code Changes: October 2018 Update MLN Matters Article — New
- 2018 DMEPOS Fee Schedule: October Update MLN Matters Article — New
- Advance Care Planning Fact Sheet — Revised
- PECOS for Physicians and NPPs Booklet — Reminder
- Medicare Enrollment for Institutional Providers Booklet — Reminder
- Medicare Part D Vaccines and Vaccine Administration Fact Sheet — Reminder

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Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at *https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html*. Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU.

First Coast Service Options Phone Numbers

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

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

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

Interactive Voice Response
877-602-8816

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

Overpayments
904-791-8123

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

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

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

Puerto Rico

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

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

Fraud and abuse
Complaint Processing Unit
P. O. Box 45087

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 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries
Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Redetermination
Florida:
Medicare Part A Redetermination/Appeals
P. O. Box 3409
Jacksonville, FL 32232-5053

U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Puerto Rico
First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Special delivery/courier services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

DME regional carrier (DMERC)
DME, orthotic, prosthetic device, take-home supply, oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare
Palmetto GBA
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health/hospice intermediary
Palmetto GBA
Medicare Part A
34650 US HWY 19N
Palm Harbor, FL 34684

Contact CMS

Centers for Medicare & Medicaid Services (CMS)
(https://www.cms.gov/)
Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations
ROATLFM@CMS.HHS.GOV

Office of Inspector General (OIG)
Medicare fraud hotline
800-HHS-TIPS (800-447-8477)

Beneficiary customer service
1-800-MEDICARE (1-800-633-4227)

Hearing and speech impaired (TDD)
1-800-754-7820