Medicare A Connection
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
September 2019

In this issue

Hurricane Dorian and Medicare Disaster Related State of Florida Claims

Provider type affected

This MLN Matters® Special Edition Article is for providers and suppliers who bill Medicare Fee-For-Service (FFS).

Provider information available

The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the State of Florida on August 30, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 28, 2019, and are in effect for 90 days.

The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the disaster/ emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

More Information:

- *Current Emergencies* webpage
- *Instructions* to request an individual waiver if there is no blanket waiver

Background

Section 1135 and Section 1812(f) Waivers

As a result of this PHE, apply the following to claims for which Medicare payment is based on a "formal waiver" including, but not limited to, Section 1135 or Section 1812(f) of the Act:

1. The "DR" (disaster related) condition code for institutional billing, i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450.
2. The "CR" (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional, i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.

Medicare FFS Questions & Answers (Q&As) available on the *Waivers and Flexibilities webpage* apply to items and

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Contents

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

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

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services for Medicare beneficiaries in the current disaster or emergency. These Q&As are displayed in two files:

- Q&As that apply *without any Section 1135* or other formal waiver.
- Q&As apply only *with a Section 1135* waiver or, when applicable, a Section 1812(f) waiver.

Blanket waivers issued by CMS

You do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities (SNFs)

- Section 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a 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 disaster or emergency. 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: This waiver provides relief to SNFs 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).
- To ensure the correct processing of home health disaster related claims, Medicare Administrative Contractors (MACs) are allowed to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs).

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 inpatient prospective payment system (IPPS) hospitals that, as a result of disaster or emergency, 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 the disaster or emergency. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients.)

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 a disaster or emergency, 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 disaster or emergency. 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 a disaster or emergency, 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

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cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. 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

CMS has determined it is appropriate to issue a blanket waiver where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. 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 disaster or emergency.

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*.

Extension for Medicare Geographic Classification Review Board (MGCRB) Applications

CMS has granted an extension to the deadline of application re-classification requirements located at 42 CFR § 412.256 for the affected areas due to the disaster or emergency. Applications for reclassifications from hospitals in these areas must be received by the MGCRB not later than October 1, 2019.

Extension for Inpatient Prospective Payment System (IPPS) Wage Index Revisions

Allows Hospital Wage Index Development Time Table for hospitals in a disaster or emergency area to request revisions to and provide documentation for their Worksheet S-3 wage data and occupational mix data as included in the preliminary Public Use Files (PUFs), respectively.

CMS has granted an extension for hospitals in the affected area. MACs must receive the revision requests and supporting documentation by October 1, 2019. If hospitals encounter difficulty meeting this extended deadline, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Medicare Advantage Plan or other Medicare Health Plan Beneficiaries

CMS reminds suppliers that Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare Health Plans should contact their plan directly to find out how it replaces DMEPOS damaged or lost in an emergency or disaster. Beneficiaries who do not have their plan's contact information can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

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 disaster or emergency.

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
September 3, 2019	Initial article released.

MLN Matters® Number: SE19018
Article Release Date: September 3, 2019
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

Hurricane Dorian and Medicare Disaster Related Commonwealth of Puerto Rico Claims

Provider type affected

This MLN Matters® Special Edition Article is for providers and suppliers who bill Medicare Fee-For-Service (FFS).

Provider information available

The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the Commonwealth of Puerto Rico on August 28, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 26, 2019, and are in effect for 90 days.

The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the disaster/emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

More Information:

- *Current Emergencies* webpage
- *Instructions* to request an individual waiver if there is no blanket waiver

Background

Section 1135 and Section 1812(f) Waivers

As a result of this PHE, apply the following to claims for which Medicare payment is based on a "formal waiver" including, but not limited to, Section 1135 or Section 1812(f) of the Act:

1. The "DR" (disaster related) condition code for institutional billing, i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450.
2. The "CR" (catastrophe/disaster related) modifier for Part B billing, both institutional and non-institutional, i.e., claims submitted using the ASC X12 837 professional claim format or paper Form CMS-1500 or, for pharmacies, in the NCPDP format.

Medicare FFS Questions & Answers (Q&As) available on the *Waivers and Flexibilities webpage* apply to items and services for Medicare beneficiaries in the current disaster or emergency. These Q&As are displayed in two files:

- Q&As that apply *without any Section 1135* or other formal waiver.
- Q&As apply only *with a Section 1135* waiver or, when applicable, a Section 1812(f) waiver.

Blanket waivers issued by CMS

You do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities (SNFs)

- Section 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a 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 disaster or emergency. 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: This waiver provides relief to SNFs 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).
- To ensure the correct processing of home health disaster related claims, Medicare Administrative Contractors (MACs) are allowed to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs).

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 inpatient prospective payment system (IPPS) hospitals that, as a result of disaster or emergency, 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 the disaster or emergency. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients.)

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 a disaster or emergency, 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 disaster or emergency. This waiver may be utilized where the hospital's acute care

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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 a disaster or emergency, 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 disaster or emergency. 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

CMS has determined it is appropriate to issue a blanket waiver where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. 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 disaster or emergency.

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*.

Extension for Medicare Geographic Classification Review Board (MGCRB) Applications

CMS has granted an extension to the deadline of application re-classification requirements located at 42 CFR § 412.256 for the affected areas due to the disaster or emergency. Applications for reclassifications from hospitals in these areas must be received by the MGCRB not later than October 1, 2019.

Extension for Inpatient Prospective Payment System (IPPS) Wage Index Revisions

Allows Hospital Wage Index Development Time Table for hospitals in a disaster or emergency area to request revisions to and provide documentation for their Worksheet S-3 wage data and occupational mix data as included in the preliminary Public Use Files (PUFs), respectively.

CMS has granted an extension for hospitals in the affected area. MACs must receive the revision requests and supporting documentation by October 1, 2019. If hospitals encounter difficulty meeting this extended deadline, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Medicare Advantage Plan or other Medicare Health Plan Beneficiaries

CMS reminds suppliers that Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare Health Plans should contact their plan directly to find out how it replaces DMEPOS damaged or lost in an emergency or disaster. Beneficiaries who do not have their plan's contact information can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

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 disaster or emergency.

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
August 30, 2019	Initial article released.

MLN Matters® Number: SE19017
Article Release Date: August 30, 2019
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

Hurricane Dorian and Medicare Disaster Related State of North Carolina Claims

Provider type affected

This MLN Matters® Special Edition Article is for providers and suppliers who bill Medicare Fee-For-Service (FFS).

Provider information available

The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the State of North Carolina on September 4, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 1, 2019, and are in effect for 90 days.

The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the disaster/emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

More Information:

- *Current Emergencies* webpage
- *Instructions* to request an individual waiver if there is no blanket waiver

Background

Section 1135 and Section 1812(f) Waivers

As a result of this PHE, apply the following to claims for which Medicare payment is based on a "formal waiver" including, but not limited to, Section 1135 or Section 1812(f) of the Act:

1. The "DR" (disaster related) condition code for institutional billing, i.e., claims submitted using the ASC X12 837 institutional claims format or paper Form CMS-1450.
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Medicare FFS Questions & Answers (Q&As) available on the *Waivers and Flexibilities webpage* apply to items and services for Medicare beneficiaries in the current disaster or emergency. These Q&As are displayed in two files:

- Q&As that apply *without any Section 1135* or other formal waiver.
- Q&As apply only *with a Section 1135* waiver or, when applicable, a Section 1812(f) waiver.

Blanket waivers issued by CMS

You do not need to apply for the following approved blanket waivers:

Skilled Nursing Facilities (SNFs)

- Section 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a 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 disaster or emergency. 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: This waiver provides relief to SNFs 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).
- To ensure the correct processing of home health disaster related claims, Medicare Administrative Contractors (MACs) are allowed to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs).

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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 inpatient prospective payment system (IPPS) hospitals that, as a result of disaster or emergency, 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 the disaster or emergency. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients.)

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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 a disaster or emergency, 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 disaster or emergency. This

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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.

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Extension for Medicare Geographic Classification Review Board (MGCRB) Applications

CMS has granted an extension to the deadline of application re-classification requirements located at 42 CFR § 412.256 for the affected areas due to the disaster or emergency. Applications for reclassifications from hospitals in these areas must be received by the MGCRB not later than October 1, 2019.

Extension for Inpatient Prospective Payment System (IPPS) Wage Index Revisions

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Document history

Date of change	Description
September 5, 2019	Initial article released.

MLN Matters® Number: SE19020
Article Release Date: September 5, 2019
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation N/A

Hurricane Dorian and Medicare Disaster-Related States of Georgia and South Carolina claims

Provider type affected

This MLN Matters® Special Edition Article is for providers and suppliers who bill Medicare Fee-For-Service (FFS).

Provider information available

The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the States of Georgia and South Carolina on September 2, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 29, 2019, for Georgia, and retroactive to August 31, 2019, for South Carolina. The PHE is in effect for 90 days.

The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the disaster/emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

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- 42 CFR 483.20: This waiver provides relief to SNFs 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).
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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 a disaster or emergency, 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 disaster or emergency. 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

CMS has determined it is appropriate to issue a blanket waiver where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. 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 disaster or emergency.

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*.

Extension for Medicare Geographic Classification Review Board (MGCRB) Applications

CMS has granted an extension to the deadline of application re-classification requirements located at 42 CFR § 412.256 for the affected areas due to the disaster or emergency. Applications for reclassifications from hospitals in these areas must be received by the MGCRB not later than October 1, 2019.

Extension for Inpatient Prospective Payment System (IPPS) Wage Index Revisions

Allows Hospital Wage Index Development Time Table for hospitals in a disaster or emergency area to request revisions to and provide documentation for their Worksheet S-3 wage data and occupational mix data as included in the preliminary Public Use Files (PUFs), respectively.

CMS has granted an extension for hospitals in the affected area. MACs must receive the revision requests and supporting documentation by October 1, 2019. If hospitals encounter difficulty meeting this extended deadline, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Medicare Advantage Plan or other Medicare Health Plan Beneficiaries

CMS reminds suppliers that Medicare beneficiaries enrolled in a Medicare Advantage or other Medicare Health Plans should contact their plan directly to find out how it replaces DMEPOS damaged or lost in an emergency or disaster. Beneficiaries who do not have their plan's contact information can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

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 disaster or emergency.

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
September 4, 2019	Initial article released.

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Implementation N/A

New Medicare Beneficiary Identifier (MBI) Get it, Use it

***Note**: This article was reissued on August 19, 2019, to show that all new Medicare cards have been mailed, to encourage providers to use MBIs now to protect patients' identities, to emphasize that providers must use MBIs beginning January 1, 2020, and to explain the rejection codes providers will get if they submit a HICN after January 1, 2020. This information was previously published in the March 2019 Medicare A Connection, pages 16-18.*

Provider type affected

This Special Edition MLN Matters® Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs) and Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

Provider action needed

Use MBIs now for all Medicare transactions. The Centers for Medicare & Medicaid Services (CMS) finished mailing new Medicare cards. The new cards without Social Security Numbers (SSNs) offer better identity protection. Help protect your patients' personal identities by getting their MBIs and using them for Medicare business, including claims submission and eligibility transactions.

Starting January 1, 2020, even for services provided before this date, you must use MBIs. With a few exceptions, Medicare will reject claims you submit with Health Insurance Claim Numbers (HICNs.) Medicare will reject all eligibility transactions you submit with HICNs.

There are 3 ways you and your office staff can get MBIs:

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare cards when they come for care. If they didn't get a new card, give them the Get Your New Medicare Card flyer in *English* or *Spanish*.

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

You can look up MBIs for your Medicare patients when they don't or can't give them. Sign up for the Portal to use the tool. You can use this tool even after the end of the transition period – the tool doesn't end on December 31, 2019. Even if your patients are in a Medicare Advantage Plan, you can look up their MBIs to bill for things like indirect medical education.

You must have your patient's SSN for the search and it may differ from the HICN, which uses the SSN of the primary wage earner. If your Medicare patient doesn't want to give the SSN, tell your patient to log into *mymedicare.gov* to get the MBI.

If the look-up tool returns a last name matching error and the beneficiary's last name includes a suffix, such as Jr. Sr. or III, try searching without and with the suffix as part of the last name.

3. Check the remittance advice

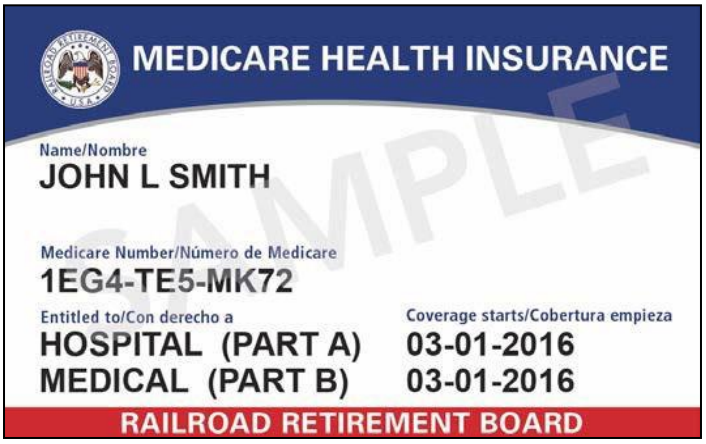
We'll also return the MBI on every remittance advice when you submit claims with valid and active HICNs through December 31, 2019. Get the MBI from the remittance advice and save it in your systems to use with your next Medicare transaction.

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to remove SSNs from all Medicare cards by April 2019. CMS replaced the SSN-based HICN with a new, randomly generated MBI. The new MBI is noticeably different than the HICN. **Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.** The MBI uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers **(for example, between "0" and "O").**

The Railroad Retirement Board (RRB) also mailed new Medicare cards with MBIs. The RRB logo will be in the upper left corner and "Railroad Retirement Board" at the bottom, but you can't tell from looking at the MBI if your patient is eligible for Medicare because they're a railroad retiree. You'll be able to identify them by the RRB logo on their card, and we'll return a "Railroad Retirement Medicare Beneficiary" message on the Fee-For-Service (FFS) MBI eligibility transaction response.

RRB issued Medicare card



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Use the MBI the same way you used the HICN. Put the MBI in the same field where you've always put the HICN. This also applies to reporting informational only and no-pay claims. **Don't use hyphens or spaces with the MBI to avoid rejection of your claim.** The MBI replaces the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. After January 1, 2020, we will reject claims submitted with HICNs, with few exceptions. You will get:

- Electronic claims- Reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims- paper notice; Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/ invalid patient identifier"

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

FFS claims submissions with:

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

FFS eligibility transactions when the:

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

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

Exceptions

There are a few exceptions when you can use either the HICN or MBI on or after January 1, 2020:

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

The MBI doesn't change Medicare benefits. **Protect the MBI as Personally Identifiable Information (PII); it is confidential like the HICN**.

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

Additional information

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

To sign up for your MAC's secure portal MBI look-up tool, visit *https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf*.

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

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

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Document history

Date of change	Description
August 19, 2019	We reissued this article to show that all new Medicare cards have been mailed, to encourage providers to use MBIs now to protect patients' identities, to emphasize that providers must use MBIs beginning January 1, 2020, and to explain the rejection codes providers will get if they submit a HICN after January 1, 2020.
March 6, 2019	We revised this article to add language that the MBI look-up tool can be used to obtain an MBI even for patients in a Medicare Advantage Plan. All other information remains the same.
December 10, 2018	The article was revised to update the language regarding when MACs can return an MBI through the MBI look up tool (page 1). All other information remains the same.
July 11, 2018	This article was revised to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2).
June 25, 2018	This article was revised to provide additional information regarding the ways your staff can get MBIs (*Provider action needed* section).
June 21, 2018	The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim. All other information remains the same.
May 25, 2018	Initial article released.

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Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting and Reporting Data for the Private Payor Rate-Based Payment System

***Note**: This article was revised on September 5, 2019, to delete incorrect information in the section titled Only Applicable Information Attributed to non-Hospital Patients is Reported, which is on page 18. All other information remains the same. This information was previously published in the March 2019 Medicare A Connection, pages 1, 3-15.*

Provider type affected

This article is for Medicare Part B clinical laboratories who submit claims to Medicare Administrative Contractors (MACs) for services furnished to Medicare beneficiaries.

Provider action needed

This article will assist the laboratory community in meeting the requirements under Section 1834A of the Social Security Act (the Act) for the Medicare Part B Clinical Laboratory Fee Schedule (CLFS). It includes clarifications for determining whether a hospital outreach laboratory meets the requirements to be an "applicable laboratory," the applicable information (that is, private payor rate data) that must be collected and reported to the Centers for Medicare & Medicaid Services (CMS), the entity responsible for reporting applicable information to CMS, the data collection and reporting periods, and the schedule for implementing the next private payor-rate based CLFS update. Also, this revised article includes information about the condensed data reporting option for reporting entities. CMS previously issued additional information about the CLFS data collection system and Advanced Diagnostic Laboratory Tests (ADLTs) through separate instructions.

Background

Section 1834A of the Act, as established by Section 216 of the Protecting Access to Medicare Act of 2014 (PAMA), required significant changes to how Medicare pays for clinical diagnostic laboratory tests under the CLFS. The CLFS final rule *Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule* (CMS-1621-F) was displayed in the Federal Register on June 17, 2016, and was published on June 23, 2016. The CLFS final rule implemented Section 1834A of the Act.

Under the CLFS final rule, reporting entities must report to CMS certain private payor rate information (applicable information) for their component applicable laboratories. In general, the payment amount for a test on the CLFS furnished on or after January 1, 2018, is equal to the weighted median of private payor rates determined for the test, based on the applicable information that laboratories collect during a data collection period and report to CMS during a data reporting period. CMS uses crosswalking or gapfilling methods to establish payment amounts for new Clinical Diagnostic Laboratory Tests (CDLTs) and CDLTs for which CMS receives no applicable information.

CMS published the Physician Fee Schedule (PFS) final rule entitled *Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2019 (CMS-1693-F)* November 23, 2018. In this final rule, CMS made two revisions to the regulatory definition of applicable laboratory:

1) Medicare Advantage plan revenues are excluded from total Medicare revenues, the denominator of the majority of Medicare revenues threshold

2) Hospitals that bill for their non-patient laboratory services use Medicare revenues from the Form CMS-1450 14x Type of Bill (TOB) to determine whether its hospital outreach laboratories meet the majority of Medicare revenues threshold and low expenditure threshold.

In addition, for the January 1, 2020, through March 31, 2020 data reporting period, CMS will allow reporting entities the option to condense certain applicable information at the Tax Identification Number (TIN)-level, instead of reporting for each applicable laboratory individually at the National Provider Identifier (NPI) level.

Applicable Laboratory

Section 1834A of the Act defines an applicable laboratory as a laboratory which receives the majority of its Medicare revenues under the CLFS and/or PFS. It also provides the authority to establish a low volume or low expenditure threshold.

Under the revised final policies for the Medicare CLFS, an applicable laboratory is a laboratory as defined under the Clinical Laboratory Improvement Amendments (CLIA) regulatory definition of a laboratory (that is, 42 C.F.R. §

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493.2) that bills Medicare Part B under its own NPI or for hospital outreach laboratories, bills Medicare Part B on the Form CMS-1450 under bill type 14x. In addition, the laboratory must meet a "majority of Medicare revenues" threshold, that is, in a data collection period it receives more than 50 percent of its Medicare revenues from one or a combination of the CLFS or the PFS. It also must meet a low expenditure threshold, that is, it receives at least $12,500 of its Medicare revenues from the CLFS in a data collection period.

For purposes of determining applicable laboratory status under the CLFS, a hospital outreach laboratory is a hospital-based laboratory that furnishes laboratory tests to patients other than admitted inpatients or registered outpatients of the hospital. A hospital outreach laboratory bills for Medicare Part B services it furnishes to non-hospital patients using the Form CMS-1450 14x Type of Bill (TOB).[1]

[1] The Form CMS-1450 14x is a type of bill as defined by the National Uniform Billing Committee. It is used in hospital claims submission and is associated with hospital laboratory services provided to non-hospital patients.

I. Determination of Applicable Laboratory Status Based on the NPI

This section includes information on how independent laboratories and physician office laboratories that bill Medicare Part B under their own NPI and hospital outreach laboratories that bill Medicare Part B under their own NPI (separate from the hospital's NPI) determine whether they are an applicable laboratory. As discussed later in this article, hospital outreach laboratories that bill Medicare Part B using the hospital's NPI must determine applicable laboratory status based on its revenues attributed to the Form CMS-1450 14x TOB.

There are four steps in determining whether a laboratory meets the requirements to be an applicable laboratory based on the laboratory's own billing NPI:

(1) Is the laboratory certified under CLIA?

(2) Does the CLIA- certified laboratory bill Medicare Part B under its own NPI?

(3) Does the laboratory meet the majority of Medicare revenues threshold?

(4) Does the laboratory meet the low expenditure threshold?

Step 1: CLIA Certification

The CLIA applies to all laboratories performing testing on human specimens for a health purpose. A laboratory must be a CLIA-certified laboratory to receive Medicare payment. Therefore, the first step in identifying an applicable laboratory is to determine whether the laboratory is CLIA certified. The CLIA regulatory definition of a laboratory is codified in regulation in 42 CFR 493.2. **Note that a facility that receives any CLIA certificate (including a CLIA certificate of waiver) is considered a laboratory as defined in 42 CFR 493.2.**

Step 2: NPI

The second step is to determine whether the CLIA-certified laboratory bills Medicare Part B under its own NPI. The NPI is the standard unique health identifier used by health care providers for billing Medicare and other payors. The National Plan and Provider Enumeration System assigns NPIs, per 45 CFR 162. CMS uses the laboratory's own billing NPI as the mechanism for defining an applicable laboratory.

Step 3: Majority of Medicare Revenues Threshold

For a CLIA-certified laboratory that bills Medicare Part B under its own NPI, to be an applicable laboratory it must meet the majority of Medicare revenues threshold. A laboratory, by its own billing NPI, meets the majority of Medicare revenues threshold if it receives more than 50 percent of its total Medicare revenues from payments under the Medicare CLFS and/or Medicare PFS. The CLFS and PFS are under Medicare Part B, also known as Original Medicare or Fee-For-Service (FFS) Medicare.

To determine whether a laboratory meets the majority of Medicare revenues threshold, the laboratory must look to its final Medicare paid claims from their MAC received by their own billing NPI during the data collection period. See the Applicable Information Section below for additional information on the concept of final paid claims.

The three steps to determine whether a laboratory meets the majority of Medicare revenues threshold are:

- First, sum the CLFS and PFS payment amounts received by the laboratory's own billing NPI during the data collection period. The revenues from the CLFS include payments for all laboratory services under the CLFS. The revenues from the PFS include all payments from all services paid under the PFS (for instance, laboratory services and services that are not laboratory services such as pathology services, evaluation and management services, and radiology services). The sum of CLFS and PFS revenues is the numerator of the majority of Medicare revenues threshold equation.
- Next, sum the total Medicare revenues received by the laboratories own billing NPI during the data collection period. Total Medicare revenues include the sum of all FFS payments under Medicare Parts A and B, prescription drug payments under Medicare Part D, and any associated Medicare beneficiary deductible or coinsurance for services furnished during the data collection period. The sum of total Medicare revenues is the denominator of the majority of Medicare revenues threshold equation.

Note: Effective January 1, 2019, Medicare Advantage plan payments under Medicare Part C shall <u>not</u> be included in the total Medicare revenues component of the majority of Medicare revenues threshold

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calculation.

- Finally, divide the sum of CLFS and PFS revenues by the sum of total Medicare revenues received during the data collection period. We provide additional information on the data collection period below.

If the Medicare revenues received from the CLFS and/or PFS are greater than 50 percent of the total Medicare revenues for the laboratory's billing NPI, the laboratory meets the majority of Medicare revenues threshold.

The majority of Medicare revenues threshold equation is:

If:

Medicare CLFS revenues (for billing NPI) + Medicare PFS revenues (for billing NPI)

_____ is >50%

Total Medicare revenues (for billing NPI)

Then: The laboratory meets the majority of Medicare revenues threshold.

Step 4: Low Expenditure Threshold

An applicable laboratory must also meet the low expenditure requirements. A laboratory (as defined under the CLIA regulations) meets the low expenditure threshold if, by its own billing NPI, receives at least $12,500 in Medicare revenues from the CLFS (under Medicare Part B) during the data collection period. To meet the low expenditure threshold, the laboratory must look to its final Medicare paid claims from the MAC received by its own billing NPI during the data collection period.

To determine whether the laboratory meets the low expenditure threshold, sum all final payments for the laboratory's own billing NPI received from Medicare CLFS services during the data collection period (completed under Step 3: Majority of Medicare Revenues Threshold). It is important to note that the low expenditure threshold applies only to CLFS services. It does not include revenues received under the PFS. In other words, to meet the low expenditure threshold, the laboratory's own billing NPI must receive at least $12,500 under only the CLFS during the data collection period.

The low expenditure threshold equation is:

Medicare CLFS revenues (for billing NPI) ≥ $12,500.

These are examples on how the majority of Medicare revenues threshold and low expenditure threshold are applied to the CLIA-certified laboratory's own billing NPI for purposes of determining whether the laboratory is an applicable laboratory:

Example 1: A laboratory organization includes five CLIA-certified laboratories. Each CLIA-certified laboratory has its own unique NPI and bills the Medicare Program (and other payors) for laboratory tests separately under each NPI. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied to each NPI in the laboratory organization. That is, individually determine whether each laboratory meets the majority of revenues threshold and low expenditure threshold. Even though all five laboratories may be under the same TIN, CMS considers each to be a separate laboratory for purposes of determining an applicable laboratory because each bills Medicare Part B for laboratory tests using its own unique NPI.

Example 2: A laboratory organization includes five CLIA-certified laboratories. Each CLIA-certified laboratory has the same NPI and bills for laboratory tests under the same NPI for each of its CLIA-certified laboratories. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied based on the combined revenues of all CLIA-certified laboratories in the organization that use the same billing NPI. In other words, for purposes of applying the applicable laboratory thresholds, CMS considers all five CLIA-certified laboratories in the laboratory organization to be a single laboratory because they all bill Medicare Part B using the same NPI.

Example 3: A laboratory organization includes five CLIA-certified laboratories. Each CLIA-certified laboratory has its own unique NPI. However, only one laboratory's NPI is used for billing all laboratory tests furnished by all five laboratories in the laboratory organization. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied to the one NPI used for billing all tests furnished by the laboratory organization.

Example 4: An entity consists of five physician offices and one CLIA-certified laboratory. All five physician offices and the CLIA-certified laboratory have the same NPI and bill for services under the same NPI. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied based on the combined revenues of all components of the entity that bill for services under the same NPI. In other words, since the physician offices and CLIA-certified laboratory all have the same NPI and bill Medicare Part B under the same NPI, CMS considers the entity to be a single laboratory for purposes of applying the majority of Medicare revenues threshold and low expenditure threshold.

Example 5: An entity consists of five physician offices and one CLIA-certified laboratory. Each of the five physician offices and the CLIA-certified laboratory have unique NPIs. The laboratory bills for laboratory tests under its own unique NPI. In this example, the majority of Medicare revenues threshold and low expenditure threshold are only applied to the CLIA-certified laboratory's own billing NPI.

Example 6: A CLIA-certified hospital outreach laboratory that performs laboratory services for non-hospital patients has its own unique NPI separate from the hospital's NPI. The hospital outreach laboratory bills Medicare Part B for laboratory tests it furnishes to non-hospital patients using its own unique NPI. In this example, the majority of Medicare revenues threshold and low expenditure

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threshold are applied to the hospital outreach laboratory's own unique NPI and not to the hospital's NPI.

Example 7: A hospital includes three CLIA-certified hospital outreach laboratories that perform laboratory services for non-hospital patients. Each CLIA-certified hospital outreach laboratory has the same NPI, separate from the hospital's NPI, and bills Medicare Part B separately for laboratory tests under the same NPI for each of its CLIA-certified hospital outreach laboratories. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied based on the combined revenues of all CLIA-certified hospital outreach laboratories of the hospital that use the same billing NPI that is separate from the hospital's NPI. In other words, for purposes of applying the applicable laboratory thresholds, CMS considers all three CLIA-certified hospital outreach laboratories of the hospital to be a single laboratory because they all bill Medicare Part B using the same unique billing NPI.

Example 8: A hospital includes three CLIA-certified hospital outreach laboratories. Each CLIA-certified hospital outreach laboratory has its own unique NPI separate from the hospital's NPI. However, the three CLIA-certified outreach laboratories use only one outreach laboratory's NPI for billing all laboratory tests furnished by all three hospital outreach laboratories of the hospital. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied to the one NPI used for billing all tests furnished by the three hospital outreach laboratories of the hospital.

Example 9: A hospital includes three CLIA-certified hospital outreach laboratories. However, only one (out of the three) has its own unique NPI separate from the hospital's NPI and bills Medicare Part B for laboratory services performed for non-hospital patients using its own unique NPI. Two (out of the three) hospital outreach laboratories bill for laboratory services performed for non-hospital patients using the hospital's NPI. In this example, the hospital outreach laboratory that bills Medicare Part B under its own unique NPI separate from the hospital's NPI uses the Medicare revenues attributed to its own billing NPI to determine whether it meets the majority of Medicare revenues threshold and low expenditure threshold.

The two hospital outreach laboratories that bill for laboratory services performed for non-hospital patients under the hospital's NPI must determine applicable laboratory status based on revenues attributed to the Form CMS-1450 14x TOB. Below, we provide instructions for determining applicable laboratory status for hospital outreach laboratories that bill Medicare Part B using the hospital's NPI.

II. Hospital Outreach Laboratories That Bill Medicare Part B under the Hospital's NPI

Similar to the preceding section, in order for hospital outreach laboratories that bill Medicare Part B using the hospital's NPI to be an applicable laboratory, the hospital outreach laboratory must be a laboratory as defined under the CLIA regulatory definition of a laboratory in 42 C.F.R. § 493.2 and meet the majority of Medicare revenues threshold and low expenditure threshold.

However, a hospital outreach laboratory that bills Medicare Part B using the hospital's NPI must determine whether it meets the majority of Medicare revenues threshold and low expenditure threshold based on revenues attributed to the Form CMS-1450 14x TOB. In other words, when using the CMS Form-1450 14x TOB for determining applicable laboratory status, the majority of Medicare revenues threshold and low expenditure threshold only applies to the hospital outreach laboratory portion of the hospital's NPI, rather than to the NPI of the entire hospital.

Therefore, if a CLIA-certified hospital outreach laboratory that bills Medicare Part B under the hospital's NPI meets the requirements of an applicable laboratory, CMS only considers the hospital outreach laboratory to be an applicable laboratory. The hospital laboratory components furnishing laboratory services to hospital patients are not part of the applicable laboratory determination.

Majority of Medicare Revenues Threshold

To be an applicable laboratory, a hospital outreach laboratory that bills Medicare Part B under the hospital's NPI must meet the majority of Medicare revenues threshold. A hospital outreach laboratory, by its revenues attributed to the Form CMS-1450 14x TOB, meets the majority of Medicare revenues threshold if it receives more than 50 percent of its total Medicare revenues from payments under the Medicare CLFS and/or Medicare PFS. The CLFS and PFS are under Medicare Part B, also known as Original Medicare or Fee-For-Service (FFS) Medicare.

To determine whether the hospital outreach laboratory (that bills using the hospital's NPI) meets the majority of Medicare revenues threshold, the laboratory must look to its final Medicare paid claims from the MAC for the 14x TOB received during the data collection period. See the Applicable Information Section below for additional information on the concept of final paid claims.

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The same three steps (as discussed in the previous section) are used to determine whether a hospital outreach laboratory (that bills Medicare Part B under the hospital's NPI) meets the majority of Medicare revenues threshold:

- First, sum the CLFS and PFS payment amounts received by the hospital outreach laboratory attributed to the 14x TOB during the data collection period. The sum of CLFS and PFS revenues is the numerator of the majority of Medicare revenues threshold equation
- Next, sum the total Medicare revenues received by the hospital outreach laboratory under the 14x TOB during the data collection period. Total Medicare revenues include the sum of all FFS payments under Medicare Parts A and B, prescription drug payments under Medicare Part D, and any associated Medicare beneficiary deductible or coinsurance for services furnished during the data collection period. The sum of total Medicare revenues is the denominator of the majority of Medicare revenues threshold equation. As noted previously, effective January 1, 2019, Medicare Advantage plan payments under Medicare Part C shall not be included in the total Medicare revenues component of the majority of Medicare revenues threshold calculation.
- Finally, divide the sum of CLFS and PFS revenues by the sum of total Medicare revenues received during the data collection period. We provide additional information on the data collection period below.

If the Medicare revenues received from the CLFS and/or PFS are greater than 50 percent of the total Medicare revenues received during the data collection period, the hospital outreach laboratory meets the majority of Medicare revenues threshold.

For hospital outreach laboratories that bill Medicare Part B under the hospital's NPI, the majority of Medicare revenues threshold equation is:

If:

$$\frac{\text{Medicare CLFS revenues (based on 14x TOB)} + \text{Medicare PFS revenues (based on 14x TOB)}}{\text{Total Medicare revenues (based on 14x TOB)}} \text{ is } >50\%$$

Then: The laboratory meets the majority of Medicare revenues threshold.

NOTE: Hospital outreach laboratories that bill Medicare Part B under the hospital's NPI, and therefore determine applicable laboratory status based on its Medicare revenues from the 14x TOB, will most likely meet the majority of Medicare revenues threshold. They will most likely meet the majority of Medicare revenues threshold because their Medicare revenues are primarily, if not entirely, derived from the CLFS and or PFS. In other words, the revenues from the CLFS and or PFS services included in the numerator are essentially the same as the total Medicare revenues included in the denominator.

Low Expenditure Threshold

To be an applicable laboratory, a hospital outreach laboratory that bills Medicare Part B under the hospital's NPI must also meet the low expenditure threshold requirement. A CLIA-certified hospital outreach laboratory meets the low expenditure threshold if, by the Form CMS-1450 14x TOB, receives at least $12,500 in Medicare revenues from the CLFS (under Medicare Part B) during the data collection period. To meet the low expenditure threshold, the hospital outreach laboratory must look to its final Medicare paid claims from the MAC received under the 14x TOB during the data collection period.

To determine whether the hospital outreach laboratory that bills Medicare Part B under the hospital's NPI meets the low expenditure threshold, sum all final payments attributed to the 14x TOB received from Medicare CLFS services during the data collection period.

It is important to note that the low expenditure threshold applies only to CLFS services. It does not include revenues received under the PFS. In other words, to meet the low expenditure threshold, the hospital outreach laboratory must receive at least $12,500 under only the Medicare CLFS during the data collection period.

These are examples on how the majority of Medicare revenues threshold and low expenditure threshold are applied to the CLIA-certified hospital outreach laboratory using the Form CMS-1450 14x TOB for purposes of determining whether the hospital outreach laboratory is an applicable laboratory:

Example 1: A CLIA-certified hospital outreach laboratory that performs laboratory services for non-hospital patients bills Medicare Part B using the same NPI as the hospital. In other words, laboratory services performed for non-hospital patients are billed on the Form CMS-1450 14x TOB using the hospital's NPI. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied to the hospital outreach laboratory's Medicare revenues received from the 14x TOB.

Example 2: A CLIA-certified hospital outreach laboratory that performs laboratory services for non-hospital patients has its own unique NPI separate from the hospital's NPI but does not use it to bill Medicare Part B. Instead, the hospital outreach laboratory continues to bill Medicare Part B for laboratory tests it furnishes to non-hospital patients using the hospital's NPI. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied to Medicare revenues received from the 14x TOB. In other words, since laboratory services performed for non-hospital patients are billed using the hospital's NPI (and not the hospital outreach laboratory's own unique billing NPI), the majority of Medicare revenues

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threshold and low expenditure threshold are applied to the hospital outreach laboratory's Medicare revenues received from the 14x TOB.

Example 3: A hospital includes three CLIA-certified hospital outreach laboratories that perform laboratory services for non-hospital patients. Each CLIA-certified hospital outreach laboratory bills Medicare Part B under the hospital's NPI. In this example, the majority of Medicare revenues threshold and low expenditure threshold are applied based on the combined revenues attributed to the 14x TOB of all CLIA-certified hospital outreach laboratories of the hospital.

In summary, applicable information (as discussed in the next section) from all applicable laboratories must be collected during the data collection period and reported by reporting entities to CMS during the data reporting period. CMS uses the applicable information reported to CMS to establish payment rates under the CLFS. All CLIA-certified laboratories (that is, both applicable laboratories and laboratories that are not applicable laboratories) are subject to the Medicare Part B private payor rate-based CLFS.

Applicable Information

The applicable laboratory along with its reporting entity (we provide more information about reporting entities below) are responsible for collecting applicable information and reporting that data to CMS.

Applicable information includes three major components:

1. The specific HCPCS code associated with the test;
2. The private payor rate for each test for which final payment has been made during the data collection period;
3. The associated volume for each test

Private Payor Defined

The definition of the term "private payor" is:

1. A health insurance issuer as defined in Section 2791(b)(2) of the Public Health Service (PHS) Act); Or
2. A group health plan as defined in Section 2791(a)(1) of the PHS Act); Or
3. A Medicare Advantage plan under Part C as defined in Section 1859(b)(1) of the Social Security Act (the Act); Or
4. A Medicaid Managed Care Organization (MCO) (as defined in Section 1903(m) of the Act).

Note: Applicable information does not include information on tests for which payment is made on a capitated basis, where payments do not reflect specific HCPCS code-level amounts. (See below for additional information on payments made on a capitated basis.) Therefore, private payor rates from Medicaid MCO plans are considered applicable information only to the extent that the individual HCPCS code for the test, private payor rate specific to the test, and the volume paid at the specific rate for the test can be identified.

These specific private payor claims data are **included** as applicable information:

- **Laboratory tests subject to the data collection and reporting requirements**. Applicable information includes the specific HCPCS code for the test, each different private payor rate for the test, and the volume associated with each private payor rate for the test. You can find a list of laboratory tests subject to the data collection and data reporting requirements at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-regulations.html* and select: *CLFS Applicable Information HCPCS Codes [ZIP, 57KB]*.
- **Final amount paid by a private payor for laboratory tests after all private payor price concessions are applied**. A final paid claim is the final amount paid by a private payor for a laboratory test during the data collection period. If a private payor pays a laboratory for a test but subsequent post-payment activities during the data collection period change that initial payment amount, the final payment is the private payor rate for purposes of determining applicable information. For example, if an initial claim was paid in error 3 months before a data collection period and then the initial claim is corrected, with final payment made by the private payor during the data collection period, the final corrected payment amount for the test is considered the private payor rate for purposes of determining applicable information. However, if an initial claim was paid in error during a data collection period and then corrected, with final paymentmade after the data collection period, the payment amount is not a private payor rate for purposes of applicable information and, therefore, is not reported to CMS.
- **Payments from secondary insurance payors.** Final payments from secondary insurance payors are considered in calculating private payor rates if the final payment was made during the data collection period. The private payor rate is 100 percent of the primary private payors' fee schedule amount which includes the final amount the primary private payor paid for the test, any patient cost sharing responsibilities required by the primary private payor (such as patient deductible and coinsurance amounts) and any payments received from a secondary insurer (if applicable). The important concept here is the reporting entity reports 100 percent of the primary private payors' fee schedule amount for the laboratory test. Reporting entities should not report payments received from secondary insurers separately.

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- **Any patient cost sharing amounts, if applicable.** For purposes of applicable information, the private payor rate for a test should include any patient cost sharing responsibilities required by the private payor (for instance, patient deductible and/or coinsurance amounts). In other words, as noted above, the private payor rate is 100 percent of the private payor's fee schedule amount for the test.
- **Multiple payment rates for the same test**. If an applicable laboratory receives more than one payment rate from the same private payor for the same test or more than one payment rate from different private payors for the same test, each unique payment rate along with the associated volume for the test code at each such rate is included as applicable information. In this case, the reporting entity must report each unique payment rate and the associated volume for the test at each such rate.
- **Appeals resolved during the data collection period**. Include payment rates (and the associated volume of tests) for claims under appeal as applicable information if the final payment amount is determined and paid by the private payor during the data collection period. For example, if a laboratory filed an appeal for a test furnished prior to a data collection period and resolved the appeal so that final payment for the test was made during the data collection period, the final rate paid is considered applicable information.
- **Non-contracted amounts for out-of-network laboratories or services.** Applicable information includes private payor rates for out-of-network laboratories if the private payor made final payment for the laboratory test during the data collection period. Non-contracted amounts paid to laboratories include any patient cost sharing amounts (for example, deductible and coinsurance responsibilities, if applicable).

Exclude these specific private payor claims data from applicable information:

- **Private payor rates for laboratory test codes paid only under the PFS**. If a laboratory test code is not paid under the CLFS and is paid under the PFS, the test code, private payor rate, and the test volume associated with the private payor rate is not applicable information.
- **Price concessions applied by a laboratory**. A laboratory's decision to waive a patient's deductible, copay, and/or coinsurance responsibility for a given test(s) must not be factored into the determination of the private payor rate for a test. Although laboratories may provide concessions to patients, it does not reflect the rates paid by private payors. As noted above, the private payor rate is 100 percent of the private payor's fee schedule amount for the test.
- **Information about denied payments.** When a private payor denies payment for a laboratory test, payments of $0.00 are not considered a private payor rate for purposes of determining applicable information under the new CLFS. In other words, when the final determination by the private payor during the data collection period is to deny the claim and therefore does not make a payment, do not report $0.00 for a laboratory test code. Report only the final paid claim amount and the associated volume of tests paid at the final paid claim amount.
- **Unresolved appeals.** Where a laboratory test claim is still under review by the private payor or is under appeal during a data collection period, the amount that has already been paid is not considered a final payment rate and therefore is not considered applicable information. Additionally, if the appeal was settled during the data collection period but final payment was not made by the private payor until after the data collection period, the payment amount cannot be used for a private payor rate and therefore is excluded from applicable information.
- **Payments made on a capitated basis.** Generally, a capitated payment is made for health care services based on a set amount for each enrolled beneficiary in the plan for a given period, regardless of whether the beneficiary receives services during the period covered by the payment. Payment is typically made on a capitated basis under a managed care arrangement. As there is no way to determine payment specifically for a given test, it cannot be reported as applicable information. Therefore, applicable information does not include information about a test for which payment is made on a capitated basis.
- **Payments where the associated test volume cannot be determined.** As discussed above, the associated volume of tests performed corresponding to each private payor rate is a component of the definition of applicable information. Where the associated volume of tests performed corresponding to each private payor rate cannot be discerned by a laboratory from the private payor's remittance, CMS does not consider those payment amounts as applicable information and you should not report them to CMS.
- **Remittances where the payor has grouped individual HCPCS code payments into an encounter or claim level payment.** When a private payor groups payments for individual HCPCS codes into a single encounter or claim-level payment that is not represented by another HCPCS code, those payments are not applicable information. In other words, if a laboratory bills individual HCPCS codes and the payor bundles

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the individual HCPCS codes into groups not represented by other HCPCS codes, the payor's bundled payment amount is not considered applicable information.

Note: In general, if a laboratory cannot correlate a private payor payment amount and the associated volume paid at that rate to a specific HCPCS code, that amount is not a private payor rate for purposes of applicable information. Estimated private payor rates and volumes are also not considered applicable information.

Schedule for data collection and reporting

The next data collection period (the period where applicable information for an applicable laboratory is obtained from claims for which the laboratory received final payment during the period) is from January 1, 2019, through June 30, 2019. A 6-month review and validation period follows the data collection period and precedes the data reporting period (the period where applicable information must be submitted to CMS).

During the 6-month review and validation period between the end of the data collection period and the beginning of the data reporting period, laboratories and reporting entities should assess whether the applicable laboratory thresholds are met. That is, determine whether each laboratory component of the reporting entity meets the majority of Medicare revenues threshold and low expenditure threshold from final Medicare paid claims received during the data collection period. Applicable laboratories and their reporting entity should also use this time to review and validate applicable information (private payor data) before it is reported to CMS.

The next data reporting period (the period where applicable information for an applicable laboratory is reported to CMS) is from January 1, 2020, through March 31, 2020. CMS will use the next data collection and reporting cycle to determine CLFS payment rates for CY 2021 through CY 2023.

This table illustrates the next data collection and reporting periods for CDLTs.

Data Collection and Reporting Periods for CDLTs

Data Collection Period	Six-Month Review and Validation Period	Data Reporting Period	Used for CLFS Rate Years
1/1/2019 – 6/30/2019	7/1/2019 – 12/31/2019	1/1/2020 – 3/31/2020	2021 – 2023
Continues every third subsequent calendar year	Continues every third subsequent calendar year	Continues every third subsequent calendar year	New CLFS rate every third year

While reporting is required every 3 years for CDLTs (that are not ADLTs), reporting entities must report applicable information annually for ADLTs, except for ADLTs in an initial data collection period (in which case a reporting entity will report by the end of the second quarter of the new ADLT initial period). We have issued additional information about ADLTs through separate instructions.

Reporting Entity

The TIN-level entity reports applicable information individually for all its laboratory components that are applicable laboratories. As noted above, an applicable laboratory is a CLIA-certified laboratory and, using its billing NPI or the 14x TOB (in the case of a hospital outreach laboratory that bills Medicare Part B under the hospital's NPI), meets the majority of Medicare revenues threshold and low expenditure threshold. Please note that we discuss a condensed data reporting option later in this section.

I. Reporting for an Applicable Laboratory That Bills Medicare Part B Under its Own NPI

This section provides examples of reporting entities reporting applicable information for independent laboratories and physician office laboratories that bill Medicare Part B under their own NPI and hospital outreach laboratories that bill Medicare Part B under their own NPI (separate from the hospital's NPI). The examples below illustrate reporting entities that must report applicable information individually for all NPI-level components that are applicable laboratories:

Example 1: A TIN-level entity consists of five CLIA-certified laboratories. Each laboratory bills using its own unique NPI and all five CLIA-certified laboratories individually meet both the majority of Medicare revenues threshold and low expenditure threshold. This TIN-level entity consists of five unique applicable laboratories. In this case, the reporting entity reports applicable information associated with each individual NPI that is an applicable laboratory (not collectively for all NPIs that are applicable laboratories under the TIN). The reporting entity separates the applicable information by each NPI and submits applicable information during the data reporting period for five applicable laboratories.

Example 2: A TIN-level entity consists of five CLIA-certified laboratories, each billing for services under its own unique NPI. However, only three of the laboratories individually meet both the majority of Medicare revenues threshold and low expenditure threshold while the remaining two laboratories do not individually meet the low expenditure threshold. In other words, two of the five CLIA-certified laboratories receive less than $12,500 of revenue under the CLFS during the data collection period. This TIN-level entity consists of three unique applicable laboratories. In this case, the reporting entity will report applicable information associated with each individual NPI that is an applicable laboratory, but will not report

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information on the two individual NPIs of the laboratories that are not applicable laboratories. The reporting entity separates the applicable information by each NPI and submits applicable information during the data reporting period for three applicable laboratories.

Example 3: A TIN-level entity consists of five CLIA-certified laboratories and each laboratory has the same NPI and bills Medicare Part B under the same NPI. Collectively, the five CLIA-certified laboratories meet the majority of Medicare revenues threshold and low expenditure threshold. This TIN-level entity consists of one applicable laboratory. In this case, the reporting entity reports applicable information for all laboratories associated with the same NPI as a single applicable laboratory. In other words, in this example, CMS considers the five CLIA-certified laboratories as one applicable laboratory for purposes of reporting applicable information because they all have the same NPI and all bill Medicare Part B under the same NPI.

Example 4: A TIN-level entity includes three CLIA-certified hospital outreach laboratories. Each hospital outreach laboratory bills using its own unique NPI (separate from the hospital's NPI) and all three CLIA-certified hospital outreach laboratories individually meet both the majority of Medicare revenues threshold and low expenditure threshold. This TIN-level entity consists of three applicable laboratories. In this case, the reporting entity reports applicable information associated with each individual NPI that is an applicable laboratory (not collectively for all NPIs that are applicable laboratories under the TIN). The reporting entity separates the applicable information by each NPI and submits applicable information during the data reporting period for three applicable laboratories.

Example 5: A TIN-level entity consists of three CLIA-certified hospital outreach laboratories, each billing for services under its own unique NPI (separate from the hospital's NPI). However, only two of the laboratories individually meet both the majority of Medicare revenues threshold and low expenditure threshold while the remaining laboratory does not individually meet the low expenditure threshold. In other words, one of the three CLIA-certified hospital outreach laboratories receives less than $12,500 in revenues from the CLFS during the data collection period. This TIN-level entity consists of two applicable laboratories. In this case, the reporting entity will report applicable information associated with each individual NPI that is an applicable laboratory, but will not report information on the one individual NPI of the laboratory that is not an applicable laboratory. The reporting entity separates the applicable information by each NPI and submits applicable information during the data reporting period for two applicable laboratories.

Example 6: A TIN-level entity includes three CLIA-certified hospital outreach laboratories and all three laboratories have the same unique NPI and bill Medicare Part B under the same unique NPI (separate from the hospital's NPI). Collectively, the three CLIA-certified hospital outreach laboratories meet the majority of Medicare revenues threshold and low expenditure threshold. This TIN-level entity consists of one applicable laboratory. In this case, the reporting entity reports applicable information for all three hospital outreach laboratories associated with the same NPI as a single applicable laboratory. In other words, in this example, CMS considers the three CLIA-certified hospital outreach laboratories as one applicable laboratory for purposes of reporting applicable information because they all have the same NPI (separate from the hospital's NPI) and all bill Medicare Part B under the same NPI.

Note: For a hospital outreach laboratory that bills Medicare Part B under its own unique billing NPI (separate from the hospital's NPI), the reporting entity reports applicable information by the hospital outreach laboratory's own unique billing NPI.

II. Reporting for Hospital Outreach Laboratories That Bill Medicare Part B Under the Hospital's NPI

This section provides examples of reporting entities reporting applicable information for hospital outreach laboratories that bill Medicare Part B under the hospital's NPI. The examples below illustrate reporting entities that must report applicable information for hospital outreach laboratories that bill Medicare Part B under the hospital's NPI that are applicable laboratories:

Example 1: A TIN-level entity includes a CLIA-certified hospital outreach laboratory that performs laboratory services for non-hospital patients and bills Medicare Part B using the hospital's NPI. Based on its Medicare revenues attributed to the Form CMS-1450 14x TOB, the hospital outreach laboratory meets the majority of Medicare revenues threshold and low expenditure threshold and

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therefore is an applicable laboratory. In this example, the reporting entity reports applicable information for its hospital outreach laboratory that bills Medicare Part B under the hospital's NPI.

Example 2: A TIN-level entity consists of three CLIA-certified hospital outreach laboratories and each laboratory bills Medicare Part B under the hospital's NPI. Collectively, the three CLIA-certified hospital outreach laboratories meet the majority of Medicare revenues threshold and low expenditure threshold. This TIN-level entity consists of one applicable laboratory. In this example, the reporting entity collectively reports applicable information for its three hospital outreach laboratories that bill Medicare Part B under the hospital's NPI.

Example 3: A TIN-level entity includes three CLIA-certified hospital outreach laboratories. Two (out of the three) hospital outreach laboratories bill for laboratory services performed for non-hospital patients using the hospital's NPI. Collectively, the two CLIA-certified hospital outreach laboratories that bill using the hospital's NPI meet the majority of Medicare revenues threshold and low expenditure threshold. However, one (out of the three) bills Medicare Part B for laboratory services performed for non-hospital patients using its own unique NPI (separate from the hospital's NPI) and meets the majority of Medicare revenues threshold and low expenditure threshold. This TIN-level entity consists of two applicable laboratories.

In this example, the reporting entity reports applicable information for the hospital outreach laboratories that bill Medicare Part B for non-hospital patients under the hospital's NPI separately from the hospital outreach laboratory that bills Medicare Part B under its own unique NPI.

Note: The reporting entity must report applicable information for hospital outreach laboratories that are applicable laboratories based on the NPI used for billing Medicare Part B. That is, for hospital outreach laboratories that bill Medicare Part B under the hospital's NPI, (and therefore determines applicable laboratory status based on its Medicare revenues attributed to the 14x TOB) the reporting entity reports applicable information by the **hospital's NPI**.

Only Applicable Information Attributed to non-Hospital Patients is Reported

As discussed previously in this publication, a CLIA certified hospital outreach laboratory that bills Medicare Part B using the hospital's NPI must determine whether it meets the majority of Medicare revenues threshold and low expenditure threshold based on its Medicare revenues attributed to the Form CMS-1450 14x TOB. If a CLIA-certified hospital outreach laboratory that bills Medicare Part B under the hospital's NPI meets the requirements of an applicable laboratory, only the hospital outreach laboratory component of the hospital laboratory (that is, laboratory tests furnished to non-hospital patients) is considered an applicable laboratory. Therefore, report only applicable information attributed to the laboratory's non-hospital patients to CMS.

The reporting entity for the hospital outreach laboratory that bills Medicare Part B under the hospital's NPI, and therefore determines applicable laboratory status based on Medicare revenues attributed to the 14x TOB, may **not** report applicable information for other parts of a hospital's laboratory business such as testing performed for hospital outpatients or hospital inpatients.

III. Additional Reporting Instructions That Apply to All Applicable Laboratories

This section provides additional reporting instructions for reporting entities reporting applicable information for its component applicable laboratory(s).

Reporting Entity Must Ensure Accurate Collection and Reporting of Applicable Information

The TIN-level entity along with its applicable laboratory(s) should establish their own approach for ensuring that the TIN-level entity can report applicable information to CMS. To that end, applicable laboratories and their reporting entity should determine the best approach to collect applicable information from final paid claims data and for submitting applicable information to CMS during the data reporting period.

Voluntary Reporting is Not Permitted

The reporting entity reports only applicable information for laboratory components that are applicable laboratories (that is, laboratories that meet the definition of an applicable laboratory). Reporting entities do **not** report applicable information for laboratories that do not meet the definition of an applicable laboratory.

Example 1: A TIN-level entity consists of four NPI-level entities. Three of the NPI-level entities meet the definition of an applicable laboratory, and one NPI-level entity does not meet the definition of an applicable laboratory. In this example, the reporting entity reports applicable information to CMS for **only** the three NPI-level entities that are applicable laboratories.

Example 2: A TIN-level entity includes one hospital outreach laboratory that bills Medicare Part B under the hospital's NPI. Based on revenues attributed to the Form CMS-1450 14x TOB, the hospital outreach laboratory meets the majority of Medicare revenues threshold but does not meet the low expenditure threshold. In other words, the hospital outreach laboratory does not receive at least $12,500 in revenues from the Medicare CLFS during the data collection period. Therefore, the hospital outreach laboratory does not meet the definition of an applicable laboratory. In this example, the reporting entity does **not** report applicable information to CMS for its hospital outreach laboratory.

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Reporting Applicable Information is Not Discretionary

Reporting entities must report all applicable information for its laboratory components that are applicable laboratories. Reporting entities do **not** have the discretion to selectively omit reporting certain applicable information.

Example: An applicable laboratory has various final paid claims for laboratory tests from the data collection period that are only in "hard copy" paper format. The reporting entity along with its applicable laboratory perceives that reporting applicable information derived from the paper claims has minimal impact on the final payment rate calculated for the tests. In this case, the reporting entity **cannot** selectively omit reporting applicable information due to the perception that reporting such applicable information may not influence the final weighted median private payor rates for a given test. In this example, the reporting entity must report the applicable information obtained from the "paper-based" claims to CMS during the data reporting period.

IV. Condensed Data Reporting Option

For the next data reporting period, that is January 1, 2020, through March 31, 2020, reporting entities may condense certain applicable information at the TIN-level, instead of reporting individually for each component that is an applicable laboratory. You may use the condensed data reporting option when more than one applicable laboratory under the TIN is paid at the same private payor rate for a specific HCPCS code.

For example, if three of the reporting entity's corresponding applicable laboratories are paid the same private payor rate for a specific HCPCS code, the reporting entity may report one record of data showing the HCPCS code, the payment rate, and the associated volume, across all three applicable laboratories, rather than reporting three separate records (that is, one for each component applicable laboratory). In other words, the reporting entity may combine the volume paid at the same private payor rate for the same HCPCS code for its component applicable laboratories.

Under the condensed data reporting option, the reporting entity must select one NPI as the reporting NPI. That is, the reporting entity will designate one applicable laboratory's NPI as the reporting NPI for each instance of condensed reporting. The reporting entity can select any NPI under the TIN that meets the definition of an applicable laboratory and designate that NPI as the reporting NPI for reporting the condensed applicable information.

Note that each unique private payor rate for each laboratory test code must be reported to CMS during the data reporting period. The condensed data reporting option is only permitted when a specific laboratory test code is paid at the same private payor rate to more than one applicable laboratory under the same TIN. Unique private payor rates paid to only one applicable laboratory under the TIN, and the volume paid at such rate(s), must be reported individually by applicable laboratory.

Reporting entities have the option of condensing the volume paid at the same private payor rate for a specific HCPCS code during a data collection period across its components that are applicable laboratories. However, if the reporting entity prefers to report applicable information individually for each of its component applicable laboratories, they may continue to do so.

To illustrate how reporting entities may report condensed applicable information when three different applicable laboratories under the same TIN are paid the same private payor rate for the same laboratory test code during a data collection period, see the comparative examples below. These examples are meant to show the difference between the individual applicable laboratory data reporting method that is, by each component that is an applicable laboratory, and the condensed data reporting method and are not intended to be representative of every possible scenario.

TABLE 1a – Example of Individual Applicable Laboratory Reporting for 2020 Data Submission

NPI	HCPCS Code	Payment Rate	Volume
1	Lab Test Code (1)	$15.00	400
2	Lab Test Code (1)	$15.00	300
3	Lab Test Code (1)	$15.00	200

In this example of the individual applicable laboratory data reporting method, three applicable laboratories are paid the same private payor rate for "Lab Test Code 1". Therefore, the reporting entity reports applicable information individually for each of its component applicable laboratories.

TABLE 1b- Example of Condensed Reporting for 2020 Data Submission (TIN-Level)

Reporting NPI	HCPCS Code	Payment Rate	Volume
Designated NPI for Condensed Reporting	Lab Test Code (1)	$15.00	900

This example illustrates how the scenario presented in Table **1a** would be reported under the condensed data reporting method. The reporting entity reports applicable information by combining the volume paid at the same private payor rate for the same HCPCS code at the reporting entity level (TIN-Level). The reporting entity designates one (of its three component applicable laboratories) as the reporting NPI.

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TABLE 2a – Example of Individual Applicable Laboratory Reporting for 2020 Data Submission

NPI	HCPCS Code	Payment Rate	Volume
1	Lab Test Code (1)	$15.00	400
1	Lab Test Code (1)	$17.00	100
2	Lab Test Code (1)	$15.00	300
2	Lab Test Code (1)	$17.00	150
3	Lab Test Code (1)	$15.00	200
3	Lab Test Code (1)	$17.00	75

In this example of the individual applicable laboratory data reporting method, three applicable laboratories are paid a private payor rate of $15 for "Lab Test Code 1" and the same three applicable laboratories are also paid a private payor rate of $17 for "Lab Test Code 1." In this example, the reporting entity reports each HCPCS code and each unique private payor rate and the volume paid at each unique private payor rate individually for each of its component applicable laboratories.

TABLE 2b- Example of Condensed Reporting for 2020 Data Submission (TIN-Level)

Reporting NPI	HCPCS Code	Payment Rate	Volume
Designated NPI for Condensed Reporting	Lab Test Code (1)	$15.00	900
Designated NPI for Condensed Reporting	Lab Test Code (1)	$17.00	325

This example illustrates how the scenario presented in Table **2a** would be reported under the condensed data reporting method. The reporting entity reports applicable information by combining the volume paid at the same private payor rate for the same HCPCS code at the reporting entity level (TIN-Level). In other words, the private payor rate of $15 and associated volume is combined and the private payor rate of $17.00 and associated volume is combined.

TABLE 3a – Example of Individual Applicable Laboratory Reporting for 2020 Data Submission

NPI	HCPCS Code	Payment Rate	Volume
1	Lab Test Code (1)	$15.00	400
1	Lab Test Code (1)	$17.00	100
1	Lab Test Code (1)	$18.50	50
2	Lab Test Code (1)	$15.00	300
2	Lab Test Code (1)	$17.00	150
2	Lab Test Code (1)	$19.50	40
3	Lab Test Code (1)	$15.00	200
3	Lab Test Code (1)	$17.00	75
3	Lab Test Code (1)	$20.00	30

In this example of the individual applicable laboratory data reporting method, three applicable laboratories are paid a private payor rate of $15 for "Lab Test Code 1" and the same three applicable laboratories are also paid a private payor rate of $17 for "Lab Test Code 1". In addition, one of the three applicable laboratories is paid a private payor rate of $18.50, another applicable laboratory is paid a private payor rate of $19.50, and another applicable laboratory is paid a private payor rate of $20 for "Lab Test Code 1". The reporting entity reports the HCPCS code and each unique private payor rate and the volume paid at each unique private payor rate individually for each of its component applicable laboratories.

TABLE 3b- Example of Condensed Reporting for 2020 Data Submission (TIN-Level)

Reporting NPI	HCPCS Code	Payment Rate	Volume
Designated NPI for Condensed Reporting	Lab Test Code (1)	$15.00	900
1 Designated NPI for Condensed Reporting	Lab Test Code (1)	$17.00	325
1	Lab Test Code (1)	$18.50	50
2	Lab Test Code (1)	$19.50	40
3	Lab Test Code (1)	$20.00	30

This example illustrates how the scenario presented in Table **3a** would be reported under the condensed data reporting method. As discussed previously, the reporting entity must report each unique private payor rate for each specific HCPCS code and the associated volume paid at each such rate. Since some private payor rates are paid to only one applicable laboratory under the TIN, a combination of the condensed data reporting method and individual applicable laboratory reporting is used to report applicable information.

The condensed data reporting method may be used when more than one applicable laboratory under the TIN is paid the same private payor rate for a specific laboratory test code. In this example, the volume among the three applicable laboratories for the private payor rate of $15.00 may be combined and the volume among the three applicable laboratories for the private payor rate of $17.00 may be combined.

However, condensed reporting would **not** be permitted for the unique private payor rates for "Lab Test Code 1" that are paid to only one applicable laboratory under the same TIN. Therefore, the private payor rate of $18.50 paid to "NPI 1"; the private payor rate of $19.50 paid to

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"NPI 2"; the private payor rate of $20.00 paid to "NPI 3" and the associated volume paid at each of these unique private payor rates must be reported individually for each applicable laboratory.

Implementation Schedule

This is the schedule for implementing the next private payor rate-based CLFS update:

- Data collection period for determining CY 2021 CLFS payment rates: January 1, 2019, through June 30, 2019.
- Data reporting period for reporting entities to report private payor rate data to CMS for determining CY 2021 CLFS payment rates: January 1, 2020, through March 31, 2020.
- Annual laboratory public meeting for new tests: June/July 2020. CMS will use crosswalking or gapfilling to set rates for new tests and existing tests for which there is no private payor data collected for the CY 2021 CLFS.
- CMS publishes preliminary CLFS rates for CY 2021: Early September 2020. The public will have approximately 30 days, through early October 2020, to submit comments on the preliminary CY 2021 rates.
- CMS makes final CY 2021 CLFS rates available on the CMS website: Early November 2020.
- Implementation date for the next private payor rate-based CLFS update: January 1, 2021.

Additional information

For more information about the private payor rate-based payment system including a summary of the private payor rate-based CLFS, the CLFS final rule, related press release and fact sheet, frequently asked questions on our final policies, a PowerPoint slide presentation of the private payor rate-based CLFS and ADLTs, visit *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*.

The CLFS final rule entitled Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule (CMS-1621-F) is available at *https://www.gpo.gov/fdsys/pkg/FR-2016-06-23/pdf/2016-14531.pdf*.

The PFS final rule entitled Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2019 (CMS-1693-F) is available at *https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf*.

If you have questions about requirements for the private payor rate-based CLFS, please email them to the CLFS Inquiries mailbox at *CLFS_Inquiries@cms.hhs.gov*.

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

Document history

Date of change	Description
September 5, 2019	We revised this article to delete incorrect information in the section titled Only Applicable Information Attributed to non-Hospital Patients is Reported, which is on page 18. All other information remains the same.
February 27, 2019	Initial article released

MLN Matters® Number: SE19006 *Revised*
Article Release Date: September 5, 2019
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Your Feedback Matters

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

Claims

Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations

***Note**: This article was revised on September 5, 2019, to announce a delay of full implementation until April 2020. This information was previously published in the July 2019 Medicare A Connection, pages 3-4.*

Provider types affected

This MLN Matters® Special Edition Article is for Outpatient Prospective Payment System (OPPS) providers that have multiple service locations submitting claims to Medicare A/B Medicare Administrative Contractors (MACs).

What you need to know

This article conveys the activation of systematic validation edits to enforce the requirements in the Medicare Claims Processing Manual, Chapter 1, Section 170, which describes Payment Bases for Institutional Claims. These requirements are not new requirements. The Centers for Medicare & Medicaid Services (CMS) discussed these requirements in CRs 9613 and 9907, both of which were effective on January 1, 2017. MLN Matters articles for CRs 9613 and 9907 are available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/Downloads/MM9613.pdf* and *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9907.pdf*, respectively. Make sure your billing staff is aware of these instructions.

Background

Increasingly, hospitals operate an off-campus, outpatient, provider-based department of a hospital. In some cases, these additional locations are in a different payment locality than the main provider. For Medicare Physician Fee Schedule (MPFS) and OPPS payments to be accurate, CMS uses the service facility address of the off-campus, outpatient, provider-based department of a hospital facility to determine the locality in these cases.

Claim Level Information

Medicare outpatient service providers report the service facility location for an off-campus, outpatient, provider-based department of a hospital in the 2310E loop of the 837 institutional claim transaction. Direct Data Entry (DDE) submitters also must report the service facility location for an off-campus, outpatient, provider-based department of a hospital. Paper submitters report the service facility address information in Form Locator (FL) “01” on the paper claim form. For MPFS services, Medicare systems use this service facility information to determine the applicable payment method or locality whenever it is present.

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

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

- To report the billing provider address only in the billing provider loop 2010AA and not to report any service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters).

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

- To report the campus address where the services were rendered in the service facility location in loop 2310E if the service facility address is different from the billing provider address loop 2010AA (or in DDE MAP 171F screen for DDE submitters).

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

- To report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop 2310E (or in DDE MAP 171F screen for DDE submitters).

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

- If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters).
- If any services on the claim were rendered at more than one of the campus locations of a multi-campus provider that is not the main billing provider address, providers should report the service facility address in loop 2310E if all of the service facility addresses are different from the billing provider address in loop 2010AA (or in DDE MAP 171F screen for DDE submitters) from the first registered campus encounter of the “From” date on the claim.
- If any services on the claim were rendered at one of the campus locations of a multi-campus provider that is not the main billing provider address and services were also rendered at other off-campus department practice locations, providers should report the campus address where the services were rendered in the service facility location in loop 2310E if the service facility

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address is different from the billing provider address in loop 2010AA (or in DDE MAP 171F screen for DDE submitters).

- If no services on the claim were rendered at the billing provider address or any campus location of a multi-campus provider, providers should report the service facility address in loop 2310E (or in DDE MAP 171F screen for DDE submitters) from the first registered department practice location encounter of the "From" date on the claim.

National Testing

Round 1 Testing

During the week of July 23, 2018, through July 30, 2018, CMS performed a national trial activation of the FISS Edits 34977 and 34978 in production environments. Reason Codes 34977 (claim service facility address doesn't match provider practice file address) and 34978 (Off-campus provider claim line that contains a HCPCS must have a PN or PO) were activated. The testing was transparent to providers as most claims impacted by the test were suspended for one (1) billing cycle and then editing was turned off so the claim could continue processing as normal.

This national test brought to light that many providers are not sending the correct exact service facility location on the claim that produces an exact match with the Medicare enrolled location as based on the information entered into the PECOS for their off-campus provider departments.

Most discrepancies had to do with spelling variations. For example, in PECOS the word entered was "Road" as part of their address, but the provider entered "Rd" or "Rd." as part of their address on the claim submission. Another example, in PECOS the word entered was "STE" as part of their address, but the provider entered "Suite" as part of their address on the claim submission.

Round 2 Testing

Providers should also ensure that all practice locations are present in PECOS and if any locations are not in PECOS to submit the 855A to add the location(s). Providers can review their practice locations in PECOS and/or the confirmation letter from PECOS when they last enrolled that was received from their A/B MAC to ensure that their service facility address for their off-campus provider department locations provided on claims is an exact match.

CMS conducted a second round of national testing in November 2018. Providers should have used the time before this national testing to correct the off-campus provider department location addresses within their billing systems to match exactly PECOS for their off-campus provider departments.

Round 3 Testing

Prior to conducting round 3 testing, CMS issued instructions to the FISS maintainer to make the practice location address screen available to providers in DDE at the April 2019 system quarterly release. Starting in April 2019, the practice location screen will be available in DDE.

CMS has postponed full production implementation for three additional months to allow time for providers to adjust to the new practice location screen. CMS will continue with additional round(s) of testing to ensure that we have a smooth implementation of the edits. CMS plans to conduct a June 2019 national testing to ensure providers have used the new practice location screen tool and made necessary claims submission updates to their systems.

Round 3 Testing Update & Full Production Delayed Another Quarter

CMS has completed round 3 testing. We are in the process of analyzing the data, but at this point, we have discovered no major issues during round 3 testing. Based on stake-holder comments and to allow additional time to review the round 3 testing, however, CMS has decided to postpone full production implementation for three additional months until April 2020. Once the April 2020 Quarterly release is implemented, CMS will direct A/B MACs to permanently turn on the edits and set them up to Return-to-Provider (RTP) claims that do not exactly match. Providers can make corrections to their service facility address for a claim submitted in the DDE MAP 171F screen for DDE submitters. **Providers who need to add a new or correct an existing practice location address will still need to submit a new 855A enrollment application in PECOS.**

CMS expects that the 3 year time frame that the edits have not been active have provided ample time for providers to validate their claims submission system and the PECOS information for their off-campus provider departments are exact matches.

Additional information

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

Document history

Date of change	Description
September 5, 2019	We revised the article to announce a delay of full implementation until April 2020.
June 28, 2019	We revised this article to provide an update on Round 3 testing and to announce a delay of full implementation until October 2019.
March 26, 2019	Initial article released.

MLN Matters® Number: SE19007 *Revised*
Article Release Date: September 5, 2019
Related CR Transmittal Numbers: R1704OTN and R1783OTN
Related Change Request (CR) Number: 9613; 9907
Effective Date: N/A
Implementation N/A

Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2019 Update

Provider type affected

This MLN Matters article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

CR 11402 informs providers that the Centers for Medicare & Medicaid Services (CMS) issued payment files to the MACs based on the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule. CR 11402 amends those payment files. Please make sure your billing staffs are aware of these changes.

Background

The updated payment files are effective for services you deliver from January 1, 2019, through December 31, 2019.

Section 1848(c)(4) of the Social Security Act authorizes the Secretary of the Department of Health and Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians' services.

Summary of Changes for October 2019

1. Codes 96931 and 96934 (the global components) are changing their Relative Value Units (RVUs) as indicated in Table 1. The rationale behind this change is that the global codes (96931/96934) need to sum to the values of the professional and technical component codes (96932 and 96933 for 96931, respectively; and 96935 and 96936 for 96934, respectively). These changes apply to services as of January 1, 2019.

Table 1: Changes for the October Update to the 2019 MPFSDB

Code	Action
96931	Malpractice RVU = 0.06
96934	Non-Facility and Facility PE RVU = 1.71; Malpractice RVU = 0.05

2. The short descriptor for HCPCS Code Q5115 is being updated (as shown in Table 2) to coincide with the changes published in CR 11296, and is effective for claims with dates of service on and after July 1, 2019. You can review the article related to CR 11296 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11296.pdf*.

Table 2: Updated Short Descriptor

Code	Action
Q5115	Short descriptor = Inj truxima 10 mg

The following "J" and "Q" code updates are effective for dates of service October 1, 2019, and after. See CR 11422 for additional information. (An MLN Matters article related to CR 11422 will be available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11422.pdf*.) See Table 3 for a list of the code updates.

Table 3: Code Updates

Code	Action
J0121	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J0122	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J0222	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J0291	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J0593	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J0641	Short Descriptor = Inj., levoleucovorin, 0.5 mg
J1096	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J1097	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J1303	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J1942	Procedure Status = I
J1943	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J1944	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J2794	Short Descriptor = Inj risperdal consta, 0.5mg
J2798	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J3031	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J3111	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J7311	Short Descriptor = Inj., retisert, 0.01 mg
J7313	Short Descriptor = Inj., iluvien, 0.01 mg

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Code	Action
J7314	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J7331	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J7332	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J7401	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J9118	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J9119	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J9204	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J9210	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J9269	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
J9313	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4122	Short Descriptor = Dermacell, awm, porous sq cm
Q4165	Short Descriptor = Keramatrix, Kerasorb sq cm
Q4184	Short Descriptor = Cellesta or duo per sq cm
Q4205	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4206	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4208	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4209	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4210	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.

Code	Action
Q4211	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4212	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4213	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4214	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.

Code	Action
Q4215	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4216	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4217	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4218	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4219	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4220	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4221	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4222	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q4226	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q5116	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q5117	Procedure Status = E; there are no RVUs, payment policy indicators do not apply.
Q5118	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, they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 11402, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4362CP.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 16, 2019	Initial article released.

MLN Matters® Number: MM11402
Related CR Release Date: August 16, 2019
Related CR Transmittal Number: R4362CP
Related Change Request (CR) Number: 11402
Effective Date: January 1, 2019
Implementation Date: October 7, 2019

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 webpage* 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 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* 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.

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

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

Retired LCDs

Testosterone pellets (Testopel®) – retired Part A and Part B LCD

LCD ID number: L33412 (Florida/Puerto Rico/ U.S. Virgin Islands)

After review of the local coverage determination (LCD) for testosterone pellets (Testopel®), it was determined to retire the LCD. Therefore, the related coding guideline attachment is also being retired.

Effective date

The retirement of this LCD and related coding guideline attachment is effective for services rendered **on or after August 23, 2019.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and 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*.

Colorectal cancer screening – retired Part A and Part B LCD

LCD ID number: L36355 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the local coverage determination (LCD) for colorectal cancer screening, it was determined that it is no longer required. Therefore, the LCD and its related billing and coding article are being retired.

Effective date

The retirement of this LCD and related billing and coding article is effective for services rendered **on or after September 7, 2019.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and 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

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

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

Based on change request (CR) 11392 (ICD-10 and Other Coding Revisions to National Coverage Determinations [NCDs]-January 2020 Update) the bone mineral density studies Billing and Coding Article was revised. Current Procedural Terminology (CPT®) codes 0554T, 0555T, 0556T, 0557T, and 0558T were added to the "CPT®/ HCPCS Codes/Group 2 Codes:" section of the Billing and Coding Article.

Also, based on review of the Billing and Coding Article, the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) language was revised/clarified in the "CPT®/HCPCS Codes/Group 1 Paragraph:" section of the Billing and Coding Article.

In addition, based on review of the bone mineral density studies local coverage determination (LCD), the "Social Security Act (Title XVIII) Standard References:" section of the LCD was updated.

Effective date

The revision related to the addition of CPT® codes 0554T, 0555T, 0556T, 0557T, and 0558T is effective for claims processed **on or after September 23, 2019**, for services rendered **on or after July 1, 2019.**

The revisions related to review of the LCD and Billing and Coding Article is effective for services rendered **on or after September 10, 2019**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and 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*.

Upper eyelid and brow surgical procedures – revision to the Part A and Part B LCD

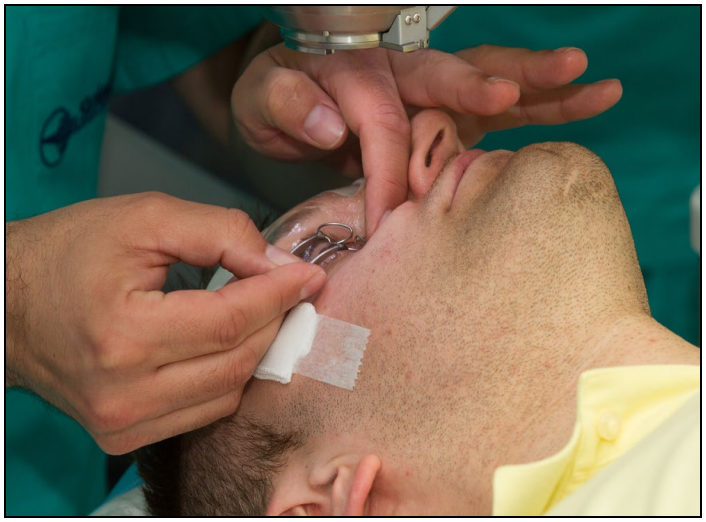
LCD ID number: L34028 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for upper eyelid and brow surgical procedures, was revised to remove all billing and coding information as well as all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT®/HCPCS Codes," "ICD-10 Codes that Support Medical Necessity," "Documentation Requirements," and "Utilization Guidelines" sections of the LCD) and place them into a newly created billing and coding article. Also, during the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually.

Effective date

This LCD revision is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 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 billing and 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*.

Vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases – revision to the Part A and Part B LCD

LCD ID number: L36962 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change requests (CRs) 11402, 11412, 11422, and 11451 (October 2019 Quarterly Updates), the "Sources of Information" section of the local coverage determination (LCD) for vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases was updated to include the U.S. Food and Drug Administration (FDA) label for Zirabev™.

Also, the related billing and coding article was revised. Healthcare Common Procedure Coding System (HCPCS) code J7999 (Injection, bevacizumab-bvzr, biosimilar, [Zirabev]) was added to the "CPT®/HCPCS Codes/Group 3 Paragraph:" section of the billing and coding article.

Effective date

The effective date for the LCD and billing and coding article revisions is for services rendered **on or after October 1, 2019.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and 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*.

Ultrasound, soft tissues of head and neck – revision to the Part A and Part B LCD

LCD ID number: L34027 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for ultrasound, soft tissues of head and neck, was revised to remove all billing and coding information as well as all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT®/HCPCS Codes," "ICD-10 Codes that Support Medical Necessity,' "Documentation Requirements" and "Utilization Guidelines" sections of the LCD) and place them into a newly created billing and coding article. Also, during the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually.

Effective date

This LCD revision is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 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 billing and 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*.

Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – revision to the Part A and Part B LCD

LCD ID number: L33410 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) was revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT®/HCPCS Codes," "ICD-10 Codes that Support Medical Necessity," "Documentation Requirements" and "Utilization Guidelines" sections of the LCD) and place them into a newly created billing and coding article. During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually. In addition, the Social Security Act and Internet-Only Manual (IOM) reference sections were updated.

Effective date

This LCD and billing and coding article revision is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 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 billing and 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*.

Noncovered Services – revision to the Part A and Part B LCD

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

Based on a local coverage determination (LCD) challenge, the noncovered services LCD was revised to remove hypoglossal nerve stimulator Current Procedural Terminology (CPT®) codes 64568, 0466T, 0467T, and 0468T from the "CPT®/HCPCS Codes" section of the LCD under the subtitle "Procedures for Part A and Part B".

Effective date

This LCD revision is effective for services rendered **on or after August 29, 2019**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and 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.

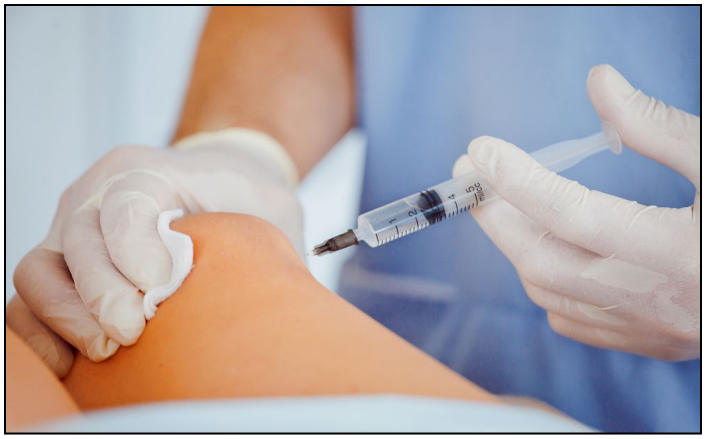
Note: To review active, future and retired LCDs, *click here*.

Viscosupplementation therapy for knee – revision to the Part A and Part B LCD

LCD ID number: L33767 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 10901, the local coverage determination (LCD) for viscosupplementation therapy for knee was revised to remove all billing and coding and all language not related to reasonable and necessary provisions ("Bill Type Codes", "Revenue Codes", "CPT®/ HCPCS Codes", "ICD-10 Codes that Support Medical Necessity", "Documentation Requirements" and "Utilization Guidelines" sections of the LCD) and place them into a newly created billing and coding article. During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually. Also, the Social Security Act and Internet-Only Manuals (IOM) reference sections were updated.

In addition, based on CRs 11402, 11412, 11422, and 11451 (October 2019 Quarterly Updates), the newly created billing and coding article was revised to include Healthcare Common Procedure Coding System (HCPCS) code J7331 for SYNOJOYNT™ and HCPCS code J7332 for TRILURON™ in the "CPT®/HCPCS Codes/Group 2 Codes" and "ICD-10 codes that Support Medical Necessity/Group 2 Paragraph" sections. Also, SYNOJOYNT™ and TRILURON™ were added to the medication administration table listed under the "Utilization Guidelines" section of the billing and coding article. In addition, the "Sources of Information" section of the LCD was updated with the U.S. Food and Drug Administration (FDA) information for SYNOJOYNT™ and TRILURON™.



Effective date

This LCD revision related to CR 10901 is effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 3, 2018.**

The LCD revision related to CRs 11402, 11412, 11422, and 11451 is effective for services rendered **on or after October 1, 2019**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and 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*.

Trastuzumab – trastuzumab biologics – revision to the Part A and Part B LCD

LCD ID number: L34026 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on change requests (CRs) 11402, 11412, 11422, 11451, and 11457 (October 2019 Quarterly Updates), the "Sources of Information" section of the local coverage determination (LCD) for trastuzumab – trastuzumab biologics was updated to include the U.S. Food and Drug Administration (FDA) label for KANJINTI™(trastuzumab-anns) and TRAZIMERA™ (trastuzumab-qyyp).

In addition, the related billing and coding article was revised. Healthcare Common Procedure Coding System (HCPCS) code Q5116 was added to the "CPT®/HCPCS Codes/Part B Group 2 Codes" and HCPCS code Q5117 was added to the "CPT®/HCPCS Codes/Part A and Part B Group 1 Codes" sections of the billing and coding article.

Also, HCPCS codes Q5116 and Q5117 were added to the "ICD-10 Codes that Support Medical Necessity/ Group 1 Paragraph" section of the billing and coding article.

Effective date

The effective date for the LCD and billing and coding article revisions is for services rendered **on or after October 1, 2019**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Additional Information

2020 ICD-10-CM Coding Changes (Part A/B, Part A and Part B)

The 2020 update to the ICD-10-CM diagnosis coding structure (change requests [CRs] 11322 and 11333) is effective for services rendered on or after October 1, 2019. First Coast Service Options Inc. (First Coast) medical policy team has evaluated all active local coverage determinations (LCDs) and related Billing and Coding Articles for diagnosis criteria that are impacted by the 2020 ICD-10-CM update. As a reminder, diagnosis codes included in the Billing and Coding Articles are surrogate to the indications addressed within the LCD and providers are required to bill the highest level of specificity for the applicable diagnosis code when reporting services. ICD-10-CM diagnosis codes have been added, revised, and deleted. The following is a list of the impacted LCDs and/or Billing and Coding Articles. **Note:** The LCDs/Billing and Coding Articles will be viewable to the public in Medicare Coverage Database on **October 10, 2019**.

In addition, based on change request (CR) 10901, the LCDs were revised to remove all billing and coding information as well as all language not related to reasonable and necessary provisions ("Bill Type Codes," "Revenue Codes," "CPT®/HCPCS Codes," "ICD-10 Codes that Support Medical Necessity,' "Documentation Requirements" and "Utilization Guidelines" sections of the LCD) and place them into the newly created billing and coding articles referenced above. Also, during the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually.

Part A/B Combined LCDs

L36767 Aortography and peripheral angiography

L36209 Cardiology – non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET

L33282 Computed Tomographic Angiography of the Chest, Heart and Coronary Arteries

L36393 Controlled Substance Monitoring and Drugs of Abuse Testing

L33583 Diagnostic and Therapeutic Esophagogastroduodenoscopy

L33667 Duplex Scan of Lower Extremity Arteries

L33669 Electrocardiography

L33670 Fundus Photography

L34003 Hepatitis B Surface Antibody and Surface Antigen

L34011 Ionized Calcium

L33380 Long-Term Wearable Electrocardiographic Monitoring (WEM)

L34014 Magnesium

L34859 Nerve Conduction Studies and Electromyography

L33693 Non-Invasive Evaluation of Extremity Veins

L33696 Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries

L34018 Parathormone (Parathyroid Hormone)

L33707 Pulmonary Diagnostic Services

L33745 Respiratory Therapeutic Services

L34023 Strapping

L33411 Surgical Management of Morbid Obesity

L33755 Susceptibility Studies

L33413 Therapy and Rehabilitation Services

L34031 Total Calcium

L33756 Transesophageal Echocardiogram

L33768 Transthoracic Echocardiography (TTE)

L33763 Vascular Stenting of Lower Extremity Arteries

L33771 Vitamin D; 25 hydroxyl, includes fraction(s), if preformed

Part A only LCDs

L33969 Diagnostic Aerosol or Vapor Inhalation

L33974 Troponin

Part B only LCDs

L33815 Diagnostic Nasal Endoscopy

L33906 Epidural

L33912 Injection of Trigger Points

L33923 Noninvasive Ear or Pulse Oximetry For Oxygen Saturation

L33941 Routine Foot Care

L33966 Vestibular Function Tests

Effective date

The LCD revisions related to CRs 11322/11333 are effective for services rendered **on or after October 1, 2019**.

The LCD revisions related to CR 10901 are effective for claims processed **on or after January 8, 2019**, for services rendered **on or after October 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 billing and 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*.

Single chamber and dual chamber permanent cardiac pacemakers – billing and coding for Part A and Part B

Article ID number: A54926 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change requests (CRs) 11322 and 11333 (Annual [2020] ICD-10-CM Update), the billing and coding article for single chamber and dual chamber permanent cardiac pacemakers was revised. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis code I48.1 was deleted and ICD-10-CM diagnosis codes I48.11 and I48.19 were added.

Effective date

This revision is effective for services rendered **on or after October 1, 2019.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and 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*.

Implantable automatic defibrillators – billing and coding for Part A and Part B

Article ID number: A56341 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 11333 (Annual [2020] ICD-10-CM Update), the billing and coding article for implantable automatic defibrillators was revised. International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) codes 0JH60FZ, 0JH63FZ, 0JPT0FZ and 0JPT3FZ were added to the "D. Other" section of the article.

Effective date

This revision is effective for services rendered **on or after October 1, 2019.**

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A billing and 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*.

Upcoming provider outreach and educational events

Medicare secondary payer: Gathering MSP information (A/B)

Date: October 23
Time: 11:30 a.m. - 1:00 p.m. ET
Type of Event: Webcast

View our complete calendar of events

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 *First Coast University*, 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 *Create 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* for details and newly scheduled educational events (teleconferences, webcasts, etc.).

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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

CMS MLN Connects®

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

MLN Connects® for Thursday, August 22, 2019

MLN Connects® for Thursday, August 22, 2019

View this edition as a PDF

News

- Overall Hospital Quality Star Ratings: Upcoming Enhancement
- Pneumococcal Vaccine Eligibility Data Issue
- Venipuncture: Comparative Billing Report in August
- SNF Provider Preview Reports: Review Your Data by September 16
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- Promoting Interoperability: 2019 Program Requirements for Hospitals
- Quality Payment Program Exception Applications
- Hospice Compare Refresh
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- CBRs: We Want Your Feedback

Compliance

- Ambulance Fee Schedule and Medicare Transports

Claims, Pricers & Codes

- MACRA Patient Relationship Categories and Codes: Reporting HCPCS Level II Modifiers

Events

- Understanding Your SNF VBP Program Performance Score Report Call — August 27
- Dementia Care: Supporting Comfort and Resident Preferences Call — September 10

MLN Matters® Articles

- New Medicare Beneficiary Identifier (MBI) Get It, Use It — Reissued
- Medicare Coverable Services for Integrative and Non-pharmacological Chronic Pain Management
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2019 Update
- Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020 — Revised

Publications

- MLN Catalog September 2019 Edition
- Ambulance Fee Schedule and Medicare Transports
- QPP: New Resources
- Getting Started with Hospice CASPER Review and Correct Reports
- Behavioral Health Integration — Revised
- Critical Access Hospital — Revised
- Swing Bed Services — Revised
- Screening Pap Tests and Pelvic Examinations Booklet — Revised
- Hospices: CASPER QM Fact Sheet — Updated

MLN Connects® for Thursday, August 29, 2019

MLN Connects® for Thursday, August 29, 2019

View this edition as a PDF

News

- Promoting Interoperability: 2019 PDMP Bonus Measure
- Beneficiary Notices Initiative Mailbox Portal
- Promoting Interoperability: 2020 Eligible Hospital eCQM Flows
- DMEPOS: Nationwide Expansion of Required PA of Pressure Reducing Support Surfaces

Compliance

- IRF Services: Follow Medicare Billing Requirements

Events

- MIPS Value Pathways RFI Webinar — September 4
- Venipuncture: Comparative Billing Report Webinar — September 5
- Dementia Care: Supporting Comfort and Resident Preferences Call — September 10
- New Medicare Card: Open Door Forum — September 11
- Hospice Outcomes & Patient Evaluation Tool ODF — September 12
- Opioids: What's an "Outlier Prescriber"? Listening Session — September 17
- Overall Hospital Star Ratings Listening Session — September 19

MLN Matters® Articles

- New Documentation Requirements for Filing Medicare Cost Reports
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2020
- Claim Status Category and Claim Status Codes Update
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule — Update from Council for Affordable Quality Healthcare (CAQH) CORE

- Home Health (HH) Patient-Driven Groupings Model (PDGM) — Revised and Additional Manual Instructions
- 2020 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments
- Healthcare Provider Taxonomy Codes (HPTCs) October 2019 Code set Update
- Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System — Revised

Publications

- Inpatient Rehabilitation Facility Prospective Payment System Booklet — Revised

Multimedia

- Physician Fee Schedule Listening Session: Audio Recording and Transcript
- IRF Appeals Settlement Call: Audio Recording and Transcript
- OPPS and ASC Listening Session: Audio Recording and Transcript
- ESRD QIP Call: Audio Recording and Transcript
- SNF PPS: Patient Driven Payment Model Videos
- Inpatient Rehabilitation Facilities (IRFs): Improving Documentation Positively Impacts CERT Web-Based Training Course — Revised

MLN Connects® for Thursday, September 5, 2019

MLN Connects® for Thursday, September 5, 2019

View this edition as a PDF

News

- New Medicare Card: Do You Refer Patients?
- IRF Appeals Settlement Option: Deadline September 17
- Quality Payment Program: MIPS Targeted Review Request Deadline September 30
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- PEPPERs for Short-term Acute Care Hospitals
- DME QIC Contract Award
- Health Care Supply Chain, Provider Self-Care, and Emergency Preparedness Resources
- September is Pain Awareness Month

Compliance

- Chiropractic Services: Comply with Medicare Billing Requirements

Events

- Dementia Care: Supporting Comfort and Resident Preferences Call — September 10
- Health Coaching and Wellness Planning for Self-Management Webinar — September 10
- New Medicare Card: Open Door Forum — September 11
- Developing a Hospice Patient Assessment Tool Special Open Door Forum — September 12
- Opioids: What's an "Outlier Prescriber"? Listening Session — September 17
- CMS Public Meeting: Action Plan to Prevent and Manage Opioid Use Disorder and Substance Use Disorder and Address Pain Management — September 20

MLN Matters® Articles

- Hurricane Dorian and Medicare Disaster Related State of Florida Claims
- Hurricane Dorian and Medicare Disaster Related States of Georgia and South Carolina Claims
- Hurricane Dorian and Medicare Disaster Related Commonwealth of Puerto Rico Claims
- 2020 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update
- Annual Clotting Factor Furnishing Fee Update 2020
- Influenza Vaccine Payment Allowances - Annual Update for 2019-2020 Season
- October 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.3
- October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- October Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Multimedia

- CMS: Beyond the Policy Podcast: Dispatches from the Blue Button Developers Conference

MLN Connects® for Thursday, September 12, 2019

MLN Connects® for Thursday, September 12, 2019

View this edition as a PDF

News

- New Medicare Card: Transition Period Ends in Less Than 4 Months
- New Enforcement Authorities to Reduce Criminal Behavior in Medicare, Medicaid, and CHIP
- Different-Day Upper and Lower Endoscopy: Comparative Billing Report in September
- Hospices: Call for Panel on Assessment Instrument and Quality Measures — Nominations due September 30
- Local Coverage Determination Meetings
- Pain Management: CDC Conversation Starters for Patients and Their Doctors
- Healthy Aging® Month: Discuss Preventive Services with your Patients

Compliance

- Bill Correctly for Device Replacement Procedures

Claims, Pricers & Codes

- Average Sales Price Files: October 2019

Events

- Opioids: What's an "Outlier Prescriber"? Listening Session — September 17
- Different-Day Upper and Lower Endoscopy: Comparative Billing Report Webinar — September 24

MLN Matters® Articles

- Hurricane Dorian and Medicare Disaster Related State

See **MLN**, page 42

MLN Connects® for Thursday, September 19, 2019

MLN Connects® for Thursday, September 19, 2019

View this edition as a PDF

News

- New Medicare Card: Why Use the MBI?
- Proposed Opioid Treatment Program Policies: Comment Deadline September 27
- Quality Payment Program: MIPS Targeted Review Request Deadline September 30
- SNF PPS Patient Driven Payment Model Resources: Get Ready for October 1
- Emergency Triage, Treat, and Transport Model: Apply by October 5
- LTCH Provider Preview Reports: Review Your Data by October 11
- IRF Provider Preview Reports: Review Your Data by October 11
- Hospice Provider Preview Reports: Review Your Data by October 11
- Prostate Cancer Awareness Month

Compliance

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

MLN Matters® Articles

- 2019-2020 Influenza (Flu) Resources for Health Care Professionals
- Billing for Hospital Part B Inpatient Services

Publications

- Medicare Enrollment for Institutional Providers — Reminder
- Medicare Enrollment Resources Educational Tool — Reminder
- PECOS FAQs Booklet — Reminder
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder

MLN

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of North Carolina Claims

- Additional Instructions to Hospitals on the Election of a Medicare-Supplemental Security Income (SSI) Component of the Disproportionate Share (DSH) Payment Adjustment for Cost Reports that Involve SSI Ratios for Fiscal Year (FY) 2004 and Earlier, or SSI Ratios for Hospital Cost-Reporting Periods for Patient Discharges Occurring Before October 1, 2004
- October 2019 Update of the Ambulatory Surgical Center (ACS) Payment System
- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update — Revised
- Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting and Reporting Data for the Private Payor Rate-Based Payment System — Revised
- 2020 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments — Revised

Publications

- Medicare Part A Cost Report Electronic Filing
- Quality Payment Program: 2019 MIPS Resources
- Advance Care Planning — Revised
- Medicare Billing: CMS Form CMS-1500 and the 837 Professional — Revised
- Medicare Secondary Payer— Revised
- Roadmap to Behavioral Health — Updated

Multimedia

- Home Health Call: Audio Recording and Transcript
- Radiation Oncology Listening Session: Audio Recording and Transcript
- SNF Value-Based Purchasing Call: Audio Recording and Transcript
- Medicare Secondary Payer Provisions Web-Based Training Course — Revised
- Quality Payment Program for Merit-based Incentive Payment System (MIPS) APMs in 2019 Web-Based Training Course — Revised
- SNF PPS: Patient Driven Payment Model Videos

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

Overpayments

904-791-6029

SPOT Help Desk

FCSOSPOTHelp@fcso.com
855-416-4199

Provider websites

English
Spanish

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)
EDOC-CS-FLINQA@fcso.com (FL/USVI)
EDOC-CS-PRINQA@fcso.com (PR)

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 44179
Jacksonville, FL 32231-4179

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)

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