

# C Medicare B CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

May 2017



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## Qualified Medicare beneficiary indicator in the Medicare fee-for-service claim processing system

### Provider types affected

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

### Provider action needed

Change request (CR) 9911 modifies the Medicare claim processing systems to help providers more readily identify the qualified Medicare beneficiary (QMB) status of each patient and to support providers' ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare's claim processing systems. This system enhancement will trigger notifications to providers (through the provider remittance advice) and to beneficiaries (through the Medicare summary notice) to reflect that the beneficiary is enrolled in the QMB program and has no

Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

### Background

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Under federal law, Medicare providers may not bill individuals enrolled in the QMB program for Medicare deductibles, coinsurance, or copayments, under any circumstances. (See Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.) State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances. Nonetheless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing

See **QMB**, page 28



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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

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Articles included in the *Medicare B 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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## About the Medicare B Connection

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website at <http://medicare.fcso.com>. In some cases, additional unscheduled special issues may be posted.

### Who receives the *Connection*

Anyone may view, print, or download the *Connection* from our provider education website(s). Providers who cannot obtain the *Connection* from the internet are required to register with us to receive a complimentary hardcopy.

Distribution of the *Connection* in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the *Connection* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare provider enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

### Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example,



“Mental Health” would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

- The section pertaining to **Electronic Data Interchange (EDI)** submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.
- In addition to the above, other sections include:
- **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

### The *Medicare B Connection* represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

### Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our “time limit” calculators on our [Appeals of claim decisions page](#). Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.



## Medicare Part B advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

### Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning

March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44>.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html>.



### ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

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

## GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (waiver of liability statement on file).

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the applicable contact section located at the end of this publication for the address in which to send written appeals requests.

## Preventing duplicate claim denials

Providers are responsible for all claims submitted to Medicare under their provider number. Preventable duplicate claims are counterproductive and costly, and continued submission to Medicare may lead to program integrity action. Please share the following information with your billing companies, vendors and clearinghouses.

Claim system edits search for duplicate, suspect duplicate and repeat services, procedures and items within paid, finalized, pending and same claim details in history. Duplicate claims and claim lines are automatically denied. Suspect duplicate claims and claim lines are suspended and reviewed by the Medicare administrative contractor (MAC) to make a determination to pay or deny. [Click here for additional information.](#)

Medicare correct coding rules include the appropriate use of condition codes and modifiers. When you submit a claim for multiple instances of a service, procedure or item, the claim should include an appropriate modifier to indicate that the service, procedure or item is not a duplicate. The modifier should be added to the second through subsequent line items for the repeat service, procedure or item. An example is listed below. In many instances, this will allow the claim to process and pay, if applicable.

However, in some instances, even when an appropriate modifier is included, the claim may deny as a duplicate, based on medically unlikely edits (MUEs). MUEs are maximum units of service that are typically reported for a service, medical procedure or item, under most instances, for a beneficiary on a single date of service. Note that these duplicate denials may not always be considered preventable.

Review your billing procedures and software. If billing for a service, procedure or item that is not a duplicate, add the appropriate modifier(s) before submitting claim. Listed below are a few examples of modifiers that may be used, as applicable. For a complete list, please review the Current Procedural Terminology (CPT®) codebook.

- **Modifier 59:** Service or procedure by the same provider, distinct or independent from other services,

performed on the same day. Services or procedures that are normally reported together but are appropriate to be billed separately under certain circumstances. Refer to *MLN Matters*® article [SE1418](#) for more details on the use of modifier 59, including coding examples.

- The Centers for Medicare & Medicaid Services (CMS) established four new modifiers, effective January 1, 2015, to define subsets of modifier 59. Refer to *MLN Matters*® article [MM8863](#) for details.
- **Modifier 76:** Repeat service or procedure by the same provider, subsequent to the original service or procedure.
- **Modifier 91:** Repeat clinical diagnostic laboratory tests. This modifier is added only when additional test results are medically necessary on the same day.
  - **Example:** Laboratory submits Medicare claim for two Lactate Dehydrogenase (LD) tests, CPT® code 83615.
    - Line 1: 83615
    - Line 2: 83615 and modifier 91
- Modifiers RT (right side) and LT (left side): Append applicable modifier to the procedure code, even if the diagnosis indicates the exact site of the procedure.
  - **Example:** Provider submits Medicare claim for diagnosis code M1711 (unilateral primary osteoarthritis, right knee) and/or diagnosis code M1712 (unilateral primary osteoarthritis, left knee). Modifier RT should be added to the procedure code billed with diagnosis code M1711. Modifier LT should be added to the procedure code billed with diagnosis code M1712.

**Note:** All claims submitted to Medicare should be supported by documentation in the patient's medical record.

Sources: CMS *MLN Matters*® [MM8121](#), *CMS internet-only manual (IOM)*, *Publication 100-04, Chapter 1, Section 120-Detection of duplicate claims*, CMS *MLN Matters*® [MM8863](#) and the *American Medical Association's (AMA) 2013 Current Procedural Terminology (CPT®) codebook*.

## New MSP type for liability set-aside arrangements

**Note:** This article was revised May 10, 2017, due to the release of an updated change request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same. This information was previously published in the [March 2017 Medicare B Connection](#), page 9.

### Provider types affected

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

### What you need to know

This article is based on CR 9893. To comply with the

Government Accountability Office (GAO) final report titled *Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333)*, the Centers for Medicare & Medicaid Services (CMS) will establish two new set-aside processes: a liability insurance Medicare set-aside arrangement (LMSA), and a no-fault insurance Medicare set-aside arrangement (NFMSA). An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare.

Please be sure your billing staffs are aware of these changes.

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# MSP

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## Background

CMS will establish two new set-aside processes: a liability Medicare set-aside arrangement (LMSA), and a no-fault Medicare set-aside arrangement (NFMSA).

CR 9893 addresses (1) the policies, procedures, and system updates required to create and utilize an LMSA and an NFMSA MSP record, similar to a Workers' Compensation Medicare set-aside arrangement (WCMSA) MSP record, and (2) instructs the MACs and shared systems when to deny payment for items or services that should be paid from an LMSA or an NFMSA fund.

Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance." Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA or NFMSA funds. However, liability and no-fault MSP claims that do not have a Medicare set-aside arrangement (MSA) will continue to be processed under current MSP claim processing instructions.

## Key points of CR 9893

Medicare will not pay for those services related to the diagnosis code (or related within the family of diagnosis codes) associated with the open LMSA or NFMSA MSP record when the claim's date of service is on or after the MSP effective date and on or before the MSP termination date. Your MAC will deny such claims using claim adjustment reason code (CARC) 201 and group code "PR" will be used when denying claims based on the open LMSA or NFMSA MSP auxiliary record.

In addition to CARC 201 and group code PR, when denying a claim based upon the existence of an open LMSA or NFMSA MSP record, your MAC will include the following remittance advice remark codes (RARCs) as appropriate to the situation:

- N723—Patient must use Liability Set Aside (LSA) funds to pay for the medical service or item.
- N724—Patient must use No-Fault Set-Aside (NFSA) funds to pay for the medical service or item.

Where appropriate, MACs may override and make payment for claim lines or claims on which:

- Auto/no-fault insurance set-asides diagnosis codes do not apply, or
- Liability insurance set-asides diagnosis codes do not apply, or are not related, or
- When the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in CR 9009.

On institutional claims, if the MAC is attempting to allow payment on the claim, the MAC will include an "N" on the '001' Total revenue charge line of the claim.

## Additional information

The official instruction, CR 9893, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1845OTN.pdf>.

The GAO report related to this issue is available at <http://www.gao.gov/products/GAO-12-333>.

CR 9009 is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R113MSP.pdf>.

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

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**Ambulance**

**Widespread probe review for ambulance services**

Ambulance services reviewed by Part B comprehensive error rate testing (CERT) for First Coast Service Options Inc. (First Coast) continue to have a high error rate. First Coast conducted two post payment widespread probe (WSP) reviews for dates of service February 1, 2016, to July 31, 2016, in response to data analysis for aberrancies to Healthcare Common Procedure Coding System (HCPCS) codes A0427 (advanced life support, level 1 emergency [ALS 1]) with RH modifier (residence to hospital); and, A0428 (basic life support, non-emergency, [BLS]) with modifier HN (hospital to extended care facility [ECF] or skilled nursing facility [SNF]).

The widespread probe results were as follows:

- HCPCS code A0427-RH (ALS) and A0425-RH- overall error rate was 15.64 percent
- HCPCS code A0428-HN (BLS) and A0425-HN- overall error rate was 33.61 percent
- HCPCS code A0425- ground mileage, per statute mile.

Services were denied for the following reasons outlined in the Centers for Medicare & Medicaid Services (CMS) internet only manual (IOM) 100-02 *Medicare Benefit Policy Manual* Chapter 10- Ambulance Services <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf>.

- The documentation submitted in the medical record did not support the patient's condition was such that use of other means of transportation was contraindicated.
- Insufficient documentation (such as the signature form was not submitted; the physician certification statement [PCS] was not submitted or was incomplete;



and/or the medical record included conflicting information).

- The medical record did not include documentation to support the service was rendered.

**First Coast actions**

In response to the high percentage of error rates and the continual risks of improper payments associated with ambulance services billed, First Coast will provide an educational webcast on July 11, 2017. Following the webcast, a prepayment medical review audit for HCPCS codes A0428 and A0425 with the HN modifier will be implemented for claims processed on or after August 1, 2017, in Florida. The new audit will be based on a threshold of claims submitted for payment in an effort to reduce the error rates for this ambulance service.

**Source:** CMS internet-only manual (IOM)

**Anesthesia**

**Payment for moderate sedation services furnished with colorectal cancer screening tests**

**Provider types affected**

This *MLN Matters*® article is intended for physicians and other providers submitting claims to Part A and B Medicare administrative contractors (MACs) for sedation services furnished with colorectal cancer screening tests.

**Provider action needed**

Change request (CR) 10075 ensures accurate program payment for moderate sedation services furnished in conjunction with screening colonoscopy services for which the beneficiary should not be charged the coinsurance or deductible. The coinsurance and deductible for these services are waived, but due to coding changes and additions to the Medicare physician fee schedule (MPFS)

database the payments for 2017 would not be accurate without this CR. Please make your billing staff aware of these changes.

**Background**

Section 4104 of the Affordable Care Act defined the term "preventive services" to include "colorectal cancer screening tests" and, as a result, it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Social Security Act for screening colonoscopies. In addition, the ACA amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes moderate sedation services as an inherent part of the screening colonoscopy

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## SEDATION

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procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the 2017 PFS final rule, the Centers for Medicare & Medicaid Services (CMS) modified coding and reporting of procedural services that include moderate sedation as an inherent part of the service, including for screening colonoscopies. CR 10075 operationalizes the existing waiver of deductible and coinsurance for moderate sedation services furnished in conjunction with and in support of colorectal cancer screening tests. Effective January 1, 2017, beneficiary coinsurance and deductible continues to not apply to the following moderate sedation claim lines when furnished in conjunction with screening colonoscopy services and when billed with modifier 33 or modifier PT:

- HCPCS code G0500: Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; patient age 5 years or older (additional time may be reported with 99153, as appropriate).
- CPT® code 99153: Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; each additional 15 minutes of intra-service time (List separately in addition to code for primary service).

MACS will not search their files to either retract payment for claim lines already paid or to retroactively pay claim lines with HCPCS code G0500 or CPT® code 99153. However, MACs will adjust such claims that you bring to their attention.

### Additional information

The official instruction, CR 10075, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3763CP.pdf>.

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

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## Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you’ll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

You’ll find First Coast’s most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).



Durable Medical Equipment

# Two new “K” codes for therapeutic continuous glucose monitors

## Provider type affected

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

## What you need to know

Change request (CR) 10013 provides the two codes for therapeutic continuous glucose monitors (CGM) that will be added to the Healthcare Common Procedure Coding System (HCPCS) code set, effective July 1, 2017. The addition of these codes (K0553 and K0554) will facilitate durable medical equipment (DME) MAC claim processing for therapeutic CGMs. Make sure that your billing staffs are aware of these two new codes.

## Background

On January 12, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a ruling (CMS-1682-R), concluding that certain CGM, referred to as therapeutic CGMs, are considered durable medical equipment (DME).

Continuous glucose monitoring systems are considered therapeutic CGMs (and therefore DME), if the equipment:

- Is approved by the Food and Drug Administration for use in place of a blood glucose monitor for making diabetes treatment decisions (for example, changes in diet and insulin dosage)
- Is generally not useful to the individual in the absence of an illness or injury
- Is appropriate for use in the home
- Includes a durable component (a component that CMS determines can withstand repeated use and has an expected lifetime of at least three years) that is capable of displaying the trending of the continuous glucose measurements

To facilitate implementation of this ruling, the following two codes will be added to the HCPCS code set effective July 1, 2017:

1. K0553 Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month’s supply
2. K0554 Receiver (Monitor), dedicated, for use with therapeutic continuous glucose monitor system.

The billing jurisdiction for both of these codes will be the DME MAC.

## Additional information

CMS 1682-R at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf>.

The official instruction, CR 10013, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3775CP.pdf>.

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

## Document History

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May 1, 2017	Initial article released.
May 18, 2017	Article revised to reflect revised change request (CR) 10013 issued May 18. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same.

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## July 2017 quarterly update for 2017 DMEPOS fee schedule

### Provider type affected

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

### Provider action needed

Change request (CR) 10071 provides the July 2017 quarterly update for the Medicare DMEPOS fee schedule, and it includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

### Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf>.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by the Social Security Act, Section 1834 at [https://www.ssa.gov/OP\\_Home/ssact/title18/1834.htm](https://www.ssa.gov/OP_Home/ssact/title18/1834.htm).

Also, payment on a fee schedule basis is a regulatory requirement at 42 *Code of Federal Regulations* (CFR) §414.102 for parenteral and enteral nutrition (PEN), splints and casts and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, Section 1834 of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas (CBAs), based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

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



The 2017 DMEPOS and PEN fee schedules and the July 2017 DMEPOS rural ZIP code file public use files (PUFs) will be available for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the data files at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched>.

### KU modifier for complex rehabilitative power wheelchair accessories & seat and back cushions

Effective July 1, 2017, the fee schedule amounts for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier 'KU' are deleted from the DMEPOS fee schedule file. These unadjusted fee schedule amounts have applied to wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). The fee schedule amounts associated with the KU modifier were mandated by Section 2 of Patient Access and Medicare Protection Act (PAMPA) effective for dates of service January 1, 2016, through December 31, 2016. Additionally, Section 16005 of the 21st Century Cures Act extended the effective date through June 30, 2017. The list of HCPCS codes to which this statutory section applied is available in Transmittal 3535, CR 9520 dated June 7, 2016.

### Therapeutic continuous glucose monitor (CGM)

As part of this update, the fee schedule amounts for the following therapeutic CGM HCPCS codes are added to the DMEPOS fee schedule file effective for dates of service on or after July 1, 2017:

- K0553 - Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month's supply
- K0554 - Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system

The fee schedule amounts apply a CMS ruling effective on or after January 12, 2017, for therapeutic CGMs. Additional

See **DMEPOS**, next page

## April 2017 quarterly update for 2017 DMEPOS fee schedule

**Note:** This article was revised May 5, 2017, to reflect a revised change request (CR) 9988 issued that day. The CR was revised to delete an example that was in the original CR. That example has been removed from the article. Also, the CR release date, transmittal number, and the web address of CR 9988 are revised in the article. All other information remains the same. This information was previously published in the [March 2017 Medicare B Connection, pages 6-7 \(A25,30\)](#).

### Provider types affected

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

### What you need to know

CR 9988 provides the April 2017 quarterly update for the Medicare DMEPOS fee schedule, and it includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

### Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual (Pub.100-04, Chapter 23, Section 60)*.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (§1834(a), (h), and (i)). Also, payment on a fee

schedule basis is a regulatory requirement at 42 *Code of Federal Regulations (CFR) §414.102* for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, Section §1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

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

The 2017 DMEPOS and PEN fee schedules and the April 2017 DMEPOS rural ZIP code file public use files (PUFs) will be available for state Medicaid agencies, managed care organizations, and other interested parties shortly after the release of the data files at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched>.

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### DMEPOS

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information on the CMS ruling is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf>.

### Additional information

The official instruction, CR 10071, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3760CP.pdf>.

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

### Document history

Date of change	Description
May 2, 2017	Initial article released

*MLN Matters*® Number: MM10071  
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 Related CR Transmittal Number: R3760CP  
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## APRIL

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### [KU modifier for complex rehabilitative power wheelchair accessories & seat and back cushions](#)

Section 16005 of the 21st Century Cures Act extends the effective date through June 30, 2017, to exclude adjustments to fees using information from CBPs for certain wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). As a result, the KU modifier fees have been added back to the DMEPOS fee schedule file effective January 1, 2017, and are effective for dates of service through June 30, 2017. The fees for items denoted with the HCPCS modifier 'KU' represent the unadjusted fee schedule amounts (the 2015 fee schedule amount updated by the 2016 and 2017 DMEPOS covered item update factor of 0.7 percent). The applicable complex rehabilitative wheelchair accessory codes are listed in CR 9520 (Transmittal 3535, dated June 7, 2016).

### [Note for change request 8822 reclassification of Certain DME to the capped rental payment category](#)

For dates of service on or after January 1, 2017, payment for the following HCPCS codes in all geographic areas is made on a capped rental basis: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.

For dates of service on or after July 1, 2016, through December 31, 2016, these HCPCS codes were reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the nine round 1 recompetete (round 1 2014) competitive bidding areas (CBAs). Program instructions on these changes were issued in CR 8822 (Transmittal 1626, dated February 19, 2016) and CR 8566 (Transmittal 1332, dated January 2, 2014). Related *MLN Matters*<sup>®</sup> articles are at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8822.pdf> and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8566.pdf>, respectively.

When submitting claims, suppliers that submit claims with more than four modifiers including when the claim is being billed with both the RT (right) and the LT (left) modifiers will include the NU (purchase of new equipment) or RR (rental) modifier as appropriate, the RT and LT modifiers and then the 99 modifier to signify that there are additional modifiers in use. On the narrative line, the supplier will include all applicable modifiers including the NU or RR, RT and LT modifiers.

### [Payment for oxygen volume adjustments and portable oxygen equipment](#)

CR 9848 (Transmittal 3679, dated December 16, 2016) titled "Payment for oxygen volume adjustments and portable oxygen equipment," updated the *Medicare Claims Processing Manual* (Pub.100-04, Chapter 20, Section 130.6) to clarify billing when the prescribed amount of stationary oxygen exceeds four liters per minute (LPM) and portable oxygen is prescribed. The QF modifier is

used to denote when the oxygen flow exceeds four LPM and portable oxygen is prescribed.

The Social Security Act (§ 1834(a)(5)(C) and (D)) requires that when there is an oxygen flow rate that exceeds four LPM that the Medicare payment amount be the higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1392) or the portable oxygen add-on amount (E0431, E0433, E0434, E1392, or K0738), and never both.

To facilitate this payment calculation, the QF modifier is added to the DMEPOS fee schedule file effective April 1, 2017, for both stationary and portable oxygen. The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen QF fee schedule amounts represent the higher of 50 percent of the monthly stationary oxygen payment amount or the fee schedule amount for the portable oxygen add-on amount.

Effective April 1, 2017, the modifier "QF" should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater four liters per minute (LPM).

### Additional information

To view the official instruction, CR 9982 issued to your MAC regarding this change, refer <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3768CP.pdf>.

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

### Document history

Date	Description
March 6, 2017	Article released
May 5, 2017	Article revised to reflect revised CR 9988. The CR was revised to delete an example that was in the original CR. That example has been removed from the article. Also, the CR release date, transmittal number, and the web address of CR 9988 are revised in the article. All other information remains the same.

*MLN Matters*<sup>®</sup> Number: MM9988 [Revised](#)  
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Evaluation & Management

# Widespread probe results for evaluation and management code 99214

Data analysis pertaining to evaluation and management (E&M) services indicates a high comprehensive error rate testing (CERT) error rate. *Current Procedural Terminology* (CPT®) code 99214 (Office/ outpatient visit, established patient) has been over-utilized compared to other E&M CPT® service codes. Errors identified include inappropriate use of high level E&M CPT® codes that were down-coded to a lower level of care, no medical documentation submitted for the date of service billed, and insufficient documentation to support CPT® 99214, which is defined in the CPT® manual as follows:

*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:*

- A detailed history;
- A detailed examination;
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

First Coast Service Options Inc. (First Coast) conducted a widespread post payment probe review for CPT® code 99214 for the top three provider specialties billing this code: 06-Cardiology, 11 (internal medicine), and 08 (family practice). The overall widespread probe error rates were 15.79 percent, 19.08 percent, and 24.46 percent,

respectively. Services were denied due to the findings below:



- Documentation did not meet the "incident to" criteria as outlined in the Centers for Medicare & Medicaid Services (CMS) internet-only manual (IOM), Publication (Pub) 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 60.2;
- No medical documentation was submitted for the date of service billed; and/or
- Services were recoded based on the medical necessity of the visit and level of E&M components demonstrated in the medical records.

First Coast and the CMS offer multiple resources addressing the documentation guidelines for E&M service levels at:

- First Coast's [Evaluation and Management \(E&M\) services page](#), offering links to tools, access to E&M interactive worksheet, FAQs, online learning, and additional resources.
- CMS [internet-only manual \(IOM\) guidelines](#) addressing multiple types and settings pertaining to E&M services.

### First Coast response

In response to the high error rate for provider specialty 08 (family practice), continued CERT errors, and risk of improper payments First Coast will implement a prepayment threshold audit for CPT® code 99214 claims submitted on or after May 3, 2017, that will apply to all providers for specialty 08 within First Coast's Florida jurisdiction.

## Episode payment model operations

**Note:** This article has been rescinded as change request (CR) 9916 was rescinded. The CR will be replaced at a later date. This information was previously published in the [March 2017 Medicare B Connection](#), pages 14-17.

MLN Matters® Number: MM9916 [Rescinded](#)  
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 Related CR Release Date: February 17, 2017  
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Related CR Transmittal #: R169DEMO  
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## Laboratory/Pathology

# MCS implementation of the restructured clinical lab fee schedule

### Provider type affected

This *MLN Matters*<sup>®</sup> article is intended for clinical laboratories and other providers submitting claims to Medicare administrative contractors (MACs) for clinical laboratory services provided to Medicare beneficiaries.

### Provider action needed

Change request (CR) 10057 instructs Medicare's multi-carrier system (MCS) maintainer to incorporate into the shared system, the revised clinical lab fee schedule (CLFS) containing the national fee schedule rates. Make sure your billing staffs are aware of these changes.

### Background

Section 216 of Public Law 113-93, the "Protecting Access to Medicare Act of 2014," added Section 1834A to the Social Security Act (the Act). This provision requires extensive revisions to the payment and coverage methodologies for clinical laboratory tests paid under the clinical laboratory fee schedule (CLFS). The Centers for Medicare & Medicaid Services (CMS) published final rule 81 FR 41035, pages 41035-41101 June 23, 2016, which implemented the provisions of the new legislation.

The final rule set forth new policies for how CMS sets rates for tests on the CLFS and is effective for dates of service on and after January 1, 2018. Beginning January 1, 2017, applicable laboratories were required to submit data to CMS which describes negotiated payment rates with private payers for any corresponding volumes of tests on the CLFS. In general, with certain designated exceptions, the payment amount for a test on the CLFS furnished on or after January 1, 2018, will be equal to the weighted median of private payer rates determined for the test, based on data collected from laboratories during a specified data collection period. In addition, a subset of tests on the CLFS, advanced diagnostic laboratory tests (ADLTs), will have different data, reporting, and payment policies associated with them. In particular, the final rule discusses CMS' proposals regarding:

- Definition of "applicable laboratory" (who must report data under Section 1834A of the Act)
- Definition of "applicable information" (what data will be reported)

- Data collection period
- Schedule for reporting data to CMS
- Definition of ADLT
- Data Integrity
- Confidentiality and public release of limited data
- Coding for new tests on the CLFS
- Phased in payment reduction

### Additional information

The official instruction, CR 10057, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1846OTN.pdf>.

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

For more information on the data collection aspects of the restructured CLFS, see *MLN Matters*<sup>®</sup> article SE17002 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE17002.pdf>.

### Document history

Date of change	Description
May 12, 2017	Initial article released.

*MLN Matters*<sup>®</sup> Number: MM10057

Related CR Release Date: May 12, 2017

Related CR Transmittal Number: R1846OTN

Related Change Request (CR) Number: CR10057

Effective Date: January 1, 2018

Implementation Date: January 2, 2018

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## CMS updates list of new CLIA waived tests

### Provider type affected

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

### Provider action needed

Change request (CR) 10055 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify MACs of the new tests so that they can accurately process claims. Make sure that your billing staffs are aware of these CLIA-related changes.

### Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The *Current Procedural Terminology* (CPT®) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attached list (that is, CPT® codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT® code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- 82465QW, 83718QW, 82947QW, 82950QW, 82951QW, 82952QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Home Test System (CardioChek Home Chol+HDL+Glu test strips)
- 82465QW, 83718QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Home Test System (CardioChek Home Chol+HDL test strips)
- 82465QW, 82947QW, 82950QW, 82951QW, 82952QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Home Test System (CardioChek Home Chol+Glu test strips)
- 82465QW, 83718QW, 82947QW, 82950QW, 82951QW, 82952QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Plus Test System (PTS Panels Chol+HDL+Glu test strips)
- 82465QW, 83718QW, December 22, 2016, Polymer Technology Systems, Inc., CardioChek Plus Test System (PTS Panels Chol+HDL test strips)
- 82465QW, 82947QW, 82950QW, 82951QW, 82952QW December 22, 2016, Polymer Technology Systems, Inc., CardioChek Plus Test System (PTS Panels Chol+Glu test strips)
- 81003QW, January 23, 2017, Germaine Laboratories, Inc. AimStrip Urine Analyzer 2 System (AimStrip Urine Reagent Strips)

- 81003QW, January 23, 2017, Germaine Laboratories, Inc. AimStrip Urine Analyzer 2 System (Fisherbrand Urine Reagent Strips)
- 87804QW, January 23, 2017, LifeSign LLC, Status Flu A+B {Nasal and Nasopharyngeal Swabs}
- 87804QW, January 23, 2017, Sekisui Diagnostics LLC, OSOM Ultra Flu A&B Test {Nasal and Nasopharyngeal Swabs}
- 80305QW, February 2, 2017, Advin Biotech, Inc. ATTEST
- 87801QW, March 6, 2017, Alere i System Respiratory Syncytial Virus

The new waived complexity code G0475 [HIV antigen/antibody, combination assay, screening] describes the testing assigned to the waived CPT® 87806QW when it is performed for screening purposes. Effective January 1, 2017, the use of G0475QW will be permitted for claims submitted by facilities with a valid, current CLIA certificate of waiver.

The new waived complexity code, 87801QW [Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique] is assigned to the testing performed by the Alere i System Respiratory Syncytial Virus test.

The attachment to CR 10055 contains the test name, manufacturer, and use for each above listed CPT® codes. You should be aware that MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust claims that you bring to their attention.

### Additional information

The official instruction, CR 10055, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3771CP.pdf>.

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

### Document history

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May 15, 2017	Initial article released.

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## Screening for hepatitis B virus infection

### Provider types affected

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

### Provider action needed

Change request (CR) 9859 provides that the Centers for Medicare & Medicaid Services (CMS) has determined that, effective September 28, 2016, Medicare will cover screening for Hepatitis B Virus (HBV) infection when performed with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations. **Medicare coinsurance and the Part B deductible are waived for this additional preventive service.** You should ensure that your billing staffs are aware of this coverage change.

### Background

Pursuant to Section 1861(ddd) of the Social Security Act (the Act), CMS may add coverage of “additional preventive services” through the national coverage determination (NCD) process. The preventive services must meet all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability.
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF).
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

The USPSTF has updated its recommendations for HBV screening, and CMS has reviewed these recommendations and supporting evidence; and has determined that the evidence is adequate to conclude that screening for HBV infection is reasonable and necessary for individuals entitled to benefits under Part A or enrolled under Part B, as described below.

Effective for services performed on or after September 28, 2016, Medicare will cover screening for HBV infection, when ordered by the beneficiary’s primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, within the context of a primary care setting with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, for beneficiaries who meet either of the following conditions:

1. Asymptomatic, non-pregnant adolescents and adults at high risk for HBV infection. “High risk” is defined as persons born in countries and regions with a high prevalence of HBV infection (that is,  $\geq 2\%$ ), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV

infection ( $\geq 8\%$ ), HIV positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection. In addition, CMS has determined that repeated screening would be appropriate annually for beneficiaries with continued high risk persons. Testing is covered annually only for persons who have continued high risk (men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) who have not received hepatitis B vaccination.

2. A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative hepatitis B surface antigen (HBsAg) test results.

For the purposes of CR 9859:

- The determination of “high risk for HBV” is identified by the primary care physician or practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.
- A primary care setting is defined by the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings **not** considered primary care settings under this definition.

### Key points of CR 9859

#### Applicable Healthcare Common Procedure Coding System (HCPCS) code

Effective for claims with dates of service on or after September 28, 2016, the claim processing instructions for payment of screening for hepatitis B virus will apply to the following HCPCS and CPT<sup>®</sup> codes:

- HBV screening for asymptomatic, non-pregnant adolescents and adults at high risk - code G0499
- HBV screening for pregnant women - CPT<sup>®</sup> codes 86704, 86706, 87340, and 87341

#### Types of bill (TOB) for institutional claims

Effective for claims with dates of service on or after September 28, 2016, you should use the following TOBs when submitting claims with G0499, 87340, 87341, 86704,

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or 86706 for HBV screening:

- Outpatient hospitals - TOB 13x (payment based on outpatient prospective payment system)
- Non-patient laboratory specimen - TOB 14x (payment based on laboratory fee schedule)
- Critical access hospitals (CAHs) - TOB 85x, (payment based on reasonable cost when the revenue code is not 096x, 097x, and 098x)
- End-stage renal disease (ESRD) - TOB 72x (payment based on ESRD prospective payment system when submitting code G0499 with diagnosis code N18.6. HBV is not separately payable for ESRD TOB 72x.)

### Professional billing requirements

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening **only when services are ordered** by the following provider specialties found on the provider's enrollment record:

- 01 - General practice
- 08 - Family practice
- 11 - Internal medicine
- 16 - Obstetrics/gynecology
- 37 - Pediatric medicine
- 38 - Geriatric medicine
- 42 - Certified nurse midwife
- 50 - Nurse practitioner
- 89 - Certified clinical nurse specialist
- 97 - Physician assistant

Claims submitted by providers other than the specialty types noted above will be denied.

Additionally, for claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening only when submitted with one of the following place of service (POS) codes:

- 11 - Physician's office
- 19 - Off-campus outpatient hospital
- 22 - On-campus outpatient hospital
- 49 - Independent clinic
- 71 - State or local public health clinic
- 81 - Independent laboratory

Claims submitted without one of the POS codes noted above will be denied.

### Diagnosis code reporting requirements

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for G0499 for HBV screening only when services are reported with both of the following diagnosis codes denoting high risk:

- Z11.59 - Encounter for screening for other viral disease

- Z72.89 - Other problems related to life style

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for G0499 for subsequent visits, only when services are reported with the following diagnosis codes:

- Z11.59 and one of the high-risk codes below:
  - F11.10-F11.99
  - F13.10-F13.99
  - F14.10-F14.99
  - F15.10-F15.99
  - Z20.2
  - Z20.5
  - Z72.52
  - Z72.53

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT® codes 86704, 86706, 87340 and 87341) in pregnant women only when services are reported with one of the following diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases, **and one of the following:**
  - Z34.00 - Encounter for supervision of normal first pregnancy, unspecified trimester
  - Z34.80 - Encounter for supervision of other normal pregnancy, unspecified trimester
  - Z34.90 - Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
  - O09.90 - Supervision of high risk pregnancy, unspecified, unspecified trimester

For claims with dates of service on or after September 28, 2016, CMS will allow coverage for HBV screening (CPT® codes 86704, 86706, 87340, and 87341) in pregnant women at high risk only when services are reported with one of the following diagnosis codes:

- Z11.59 - Encounter for screening for other viral diseases; and
- Z72.89 - Other problems related to lifestyle, and also one of the following:

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester

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Code	Description
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
O09.90	Supervision of high risk pregnancy, unspecified, unspecified trimester
O09.91	Supervision of high risk pregnancy, unspecified, first trimester
O09.92	Supervision of high risk pregnancy, unspecified, second trimester
O09.93	Supervision of high risk pregnancy, unspecified, third trimester

### Claim/service denial

When denying payment for HBV screening use, your MAC will use the appropriate claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), or group codes.

When denying services submitted on a TOB other than 13x, 14x, or 85x, they will use:

- CARC 170 - Payment is denied when performed/ billed by this type of provider. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
- RARC N95 - This provider type/provider specialty may not bill this service
- Group code CO (contractual obligation) - Assigning financial liability to the provider

When denying services when HCPCS G0499 is paid in history for claims with dates of service on and after September 28, 2016, or if the beneficiary's claim history shows claim lines containing CPT® codes 86704, 86706, 87340, and 87341 submitted in the previous 11 full months they will use the following messages:

- CARC 119 - "Benefit maximum for this time period or occurrence has been reached."
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have

web access, you may contact the contractor to request a copy of the NCD."

- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 with or without GA modifier or a claim –line is received with a GA modifier indicating a signed ABN is on file).
- Group code CO (contractual obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

When denying services for G0499, when ICD-10 diagnosis code Z72.89 and Z11.59 are not present on the claim, MACs will use:

- CARC 167 - "This (these) diagnosis(es) is (are) not covered. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO

Denying services for HBV screening, HCPCS G0499, when ICD-10 diagnosis code Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93 is present on the claim:

- CARC 167 - "This (these) diagnosis(es) is (are) not covered. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code: CO (contractual obligation)

When denying services for G0499 for subsequent visits, when ICD-10 diagnosis code Z11.59 and one of the following high-risk diagnosis codes: F11.10- F11.19, F13.10 - F13.99, F14.10 - F14.99, F15.10 - F15.99, Z20.2, Z20.5, Z72.52, or Z72.53 are not present on the claim, MACs will use:

- CARC 167 - "This (these) diagnosis(es) is (are) not covered. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available

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at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.

- Group code CO

When denying claim lines for G0499 without the appropriate POS code, MACs will use:

- CARC 171 - Payment is denied when performed by this type of provider on this type of facility. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428 - Not covered when performed in certain settings.
- Group code CO

When denying claim lines for G0499 that are not submitted from the appropriate provider specialties, MACs will use:

- CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service billed. **NOTE:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group code CO (contractual obligation) - Assigning financial liability to the provider (if a claim line-item is received with a GZ modifier indicating no signed ABN is on file).

When denying services where previous HBV screening, HCPCS 86704, 86706, 87340, or 87341, is paid during the same pregnancy period or more than two screenings are paid to women that are at high risk, they will use:

- CARC 119 - "Benefit maximum for this time period or occurrence has been reached."
- RARC N362 - "The number of days or units of service exceeds our acceptable maximum."
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is

received with a GA modifier indicating a signed ABN is on file).

- Group code CO (contractual obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

When denying claim lines for HBV screening, HCPCS G0499 for a subsequent HBV screening test for non-pregnant, high-risk beneficiary when a claim line for an initial HBV screening has not yet been posted in history, use the following messages:

- CARC B15 - This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code - CO (contractual obligation).

When denying services for HBV screening, HCPCS 86704, 86706, 87340, and 87341 that are billed without the appropriate diagnosis code MACs will use:

- CARC 50 - These are non-covered services because this is not deemed a "medical necessity" by the payer. **Note:** Refer to the 835 Healthcare Policy identification Segment (loop 2110 Service Payment information REF), if present.
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group code CO (contractual obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

### Additional notes

- HCPCS code G0499 will appear in the January 1, 2018, clinical laboratory fee schedule (CLFS), in the January 1, 2017, integrated outpatient code editor (IOCE), and in the January 1, 2017, Medicare physician fee schedule (MPFS) with indicator 'X'. HCPCS code G0499 will be effective retroactive to September 28, 2016, in the IOCE.
- Your MAC will not search for claims containing HCPCS G0499 with dates of service on or after September

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**Medicare Physician Fee Schedule**

**July update to the 2017 Medicare physician fee schedule database**

**Provider type affected**

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

**Provider action needed**

Change request (CR) 10104 informs MACs about the release of payment files based upon the 2017 Medicare physician fee schedule (MPFS) final rule. Make sure that your billing staffs are aware of these changes.

**Background**

Payment files were issued to the MACs based upon the 2017 MPFS final rule, published in the *Federal Register* November 15, 2016, to be effective for services furnished between January 1, 2017, and December 31, 2017. Section 1848(c)(4) of the Social Security Act authorizes

the Secretary to establish ancillary policies necessary to implement relative values for physicians' services.

Following is a summary of the changes for the July update to the 2017 MPFSDB.

Effective for dates of service (DOS) on and after January 1, 2017, except as noted otherwise.

CPT <sup>®</sup> /HCPCS	Action
20245	Global days = 000
52441	Endo base = 52000
64897	Co-surgery = 1
64902	Co-surgery = 1
J1725	Status = I, effective for DOS on or after July 1, 2017
P9072	Status = I, effective for DOS on or after July 1, 2017

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28, 2016, but may adjust claims that you bring to their attention.

- You should be aware that the revision to the *Medicare National Coverage Determinations Manual* is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs) (see 42 CFR Section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See Section 1869(f)(1)(A)(i) of the Social Security Act.)
- MACs will apply contractor pricing to claim lines with G0499 with dates of service September 28, 2016, through December 31, 2017.
- Deductible and coinsurance do not apply to G0499.

**Additional information**

The official instruction, CR 9859, was issued to your MAC via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3761CP.pdf>. The second transmittal updates the *NCD Manual* and it is available at

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R195NCD.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

**Document history**

Date	Description
May 17, 2017	The article was changed to clarify language under <i>Professional Billing Requirements</i> . It now reads, only when services <b>are ordered</b> by the following provider specialties found on the provider's enrollment record.
May 4, 2017	Initial article released.

*MLN Matters*<sup>®</sup> Number: MM9859  
 Related Change Request (CR) #: CR 9859  
 Related CR Release Date: April 28, 2017  
 Effective Date: September 28, 2016  
 Related CR Transmittal #: R3761CP and R195NCD  
 Implementation Date: January 1, 2018

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The following new codes have been added to the HCPCS file effective May 1, 2017. The HCPCS file coverage code is C (carrier judgment) for these new codes. Coverage and payment will be determined by the MAC (they are not part of the MPFS).

CPT® code	Short descriptor	Long descriptor
0004U	Nfct ds dna 27 resist genes	Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate
0005U	Onco prst8 3 gene ur alg	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score

The following new codes from CR 10107 have also been added to the MPFSDB effective July 1, 2017 (see *MLN Matters*® article MM10107 when it is available) for code descriptions and additional information):

Code	Action
Q9984	Procedure status = N; there are no RVUs, payment policy indicators do not apply.
Q9985	Procedure status = E; there are no RVUs, payment policy indicators do not apply

### New HCPCS and CPT® category III codes added effective July 1, 2017

Code	Modifier	Short descriptor	Long descriptor	MPFSDB indicator information
Q9987		Pathogen test for platelets	Pathogen(s) test for platelets	Procedure status X; there are no RVUs, payment policy indicators do not apply.
0469T		Rta polarize scan oc scr bi	Retinal polarization scan, ocular screening with on-site automated results, bilateral	Procedure status N; there are no RVUs, payment policy indicators do not apply.

Code	Action
Q9986	Procedure status = E; there are no RVUs, payment policy indicators do not apply
Q9988	Procedure status = X; there are no RVUs, payment policy indicators do not apply
Q9989	Procedure status = E; there are no RVUs, payment policy indicators do not apply

Refer to table below for new codes effective July 1, 2017.

### Additional information

The official instruction, CR 10104, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3772CP.pdf>.

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

### Document history

Date of change	Description
May 15, 2017	Initial article released.

*MLN Matters*® Number: MM10104  
 Related CR Release Date: May 12, 2017  
 Related CR Transmittal Number: R3772CP  
 Related Change Request (CR) Number: 10104  
 Effective Date: January 1, 2017  
 Implementation Date: July 3, 2017

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Code	Modifier	Short descriptor	Long descriptor	MPFSDB indicator information
0470T	TC, 26	Oct skn img acquisj i&r 1st	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion	Procedure status C; PC/TC indicator 1; there are no RVUs, no other payment policy indicators apply.
0471T	TC, 26	Oct skn img acquisj i&r addl	Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)	Procedure status C; PC/TC indicator 1; there are no RVUs, no other payment policy indicators apply.
0472T		Prgrmg io rta eltrd ra	Device evaluation, interrogation, and initial programming of intra- ocular retinal electrode array (eg, retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional	Procedure dtatus C; there are no RVUs, payment policy indicators do not apply.
0473T		Reprgrmg io rta eltrd ra	Device evaluation and interrogation of intra-ocular retinal electrode array (eg, retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	Procedure status C; there are no RVUs, payment policy indicators do not apply.
0474T		Insj aqueous drg dev io rsvr	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	Procedure status C; there are no RVUs, payment policy indicators do not apply.
0475T		Rec ftl car sgl 3 ch i&r	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional	Procedure status C; there are no RVUs, payment policy indicators do not apply.
0476T		Rec ftl car sgl elec tr data	Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage	Procedure status C; there are no RVUs, payment policy indicators do not apply.
0477T		Rec ftl car sgl xrtj alys	Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result	Procedure status C; there are no RVUs, payment policy indicators do not apply.
0478T		Rec ftl car 3 ch rev i&r	Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional	Procedure status C; there are no RVUs, payment policy indicators do not apply.

Preventive Services

## Implementation of new influenza virus vaccine code

### Provider types affected

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

### What you need to know

Change request (CR) 9876 provides instructions for payment and edits for the common working file (CWF) to include influenza virus vaccine code 90682 (Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use) for claims with dates of service on or after July 1, 2017. Make sure that your billing staffs are aware of these instructions.

### Background

Effective for dates of service on and after July 1, 2017, influenza virus code 90682 will be payable by Medicare. Annual Part B deductible and coinsurance amounts do not apply to this code. MACs will:

- Effective for dates of service on or after August 1, 2017, MACs will pay for code 90682 using the Centers for Medicare & Medicaid Services (CMS) Seasonal Influenza Vaccines Pricing at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html> to determine the payment rate for influenza virus vaccine code 90682.
- Pay for vaccine code 90682 on institutional claims as follows:
  - Hospitals – Types of bill (TOB) 12x and 13x, skilled nursing facilities (SNFs) – TOB 22x and 23x, home health agencies (HHAs) – TOB 34x, hospital-based renal dialysis facilities (RDFs) – TOB 72x, and critical access hospitals (CAHs) – TOB 85x, based on reasonable cost
  - Indian health service (IHS) hospitals – TOB 12x, and 13x, IHS CAHs – TOB 85x, and hospices (81x and 82x) based on the lower of the actual charge or 95 percent of the average wholesale price (AWP)
  - Comprehensive outpatient rehabilitation facility (CORF) – TOB 75x, and independent RDFs – TOB 72x, based on the lower of actual charge or 95 percent of the AWP
- MACs will pay at discretion claims for code 90682 with dates of service July 1, 2017, through July 31, 2017.

- MACs will return to the provider (RTP) institutional claims if submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017.
- MACs will deny Part B claims submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017, using the following messages:
  - Claim adjustment reason code: 181 – “Procedure code was invalid on the date of service.”
  - Remittance advice remark code: N56 – “Procedure code billed is not correct/valid for the services billed or the date of service billed.”
  - Group code: CO (contractual obligation)

In addition, effective for claims with dates of service on or after October 1, 2016, MACs will pay vaccines (influenza, PPV, and HepB) to hospices based on the lower of the actual charge or 95 percent of AWP. Coinsurance and deductibles do not apply. Further, MACs will adjust previously processed hospice claims (TOB 81x or 82x) for these vaccines with dates of service on or after October 1, 2016.

### Additional information

The official instruction, CR 9876, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3754CP.pdf>.

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

### Document history

- **February 3, 2017** – Initial article released.
- **April 21, 2017** – The article was revised to reflect a revised CR 9876 issued that day. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

*MLN Matters*<sup>®</sup> Number: MM9876  
 Related Change Request (CR) #: CR 9876  
 Related CR Release Date: April 21, 2017  
 Effective Date: July 1, 2017  
 Related CR Transmittal #: R3754CP  
 Implementation Date: July 3, 2017

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## Therapy Services

# Changes to the payment policies for reciprocal billing arrangements and fee-for-time compensation arrangements

### Provider type affected

This *MLN Matters*<sup>®</sup> article is intended for physicians, physical therapists, and other providers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

### What you need to know

This article is based on change request (CR) 10090, which implements the 21st Century Cures Act (Section 16006). Outpatient physical therapy services furnished by physical therapists in a health professional shortage area (HPSA), a medically underserved area (MUA), or in a rural area can be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner as physicians bill effective June 13, 2017.

### Background

*Section 1842(b)(6)(D)* of the Social Security Act (the Act) allows payment to be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if the first physician is unavailable to provide the services, and the services are furnished pursuant to an arrangement that is either

- Informal and reciprocal, or
- Involves per diem or other fee-for-time compensation for such services.

In addition, the services must not be provided by the second physician over a continuous period of more than 60 days unless the regular physician is called or ordered to active duty as a member of a reserve component of the Armed Forces.

Effective June 13, 2017, this same process will be available to Medicare-enrolled physical therapists that use substitute physical therapists to furnish outpatient physical therapy services in a HPSA, MUA, or a rural area.

The purpose of CR 10090 is to:

1. Implement *Section 16006* of the 21st Century Cures Act, which allows outpatient physical therapy services furnished by physical therapists in a HPSA, MUA, or in a rural area to be billed under reciprocal billing and fee-for-time compensation arrangements in the same manner as physicians bill; this is effective June 13, 2017. The term "locum tenens," which has historically been used in the manual to mean fee-for-time compensation arrangements, is being discontinued because the title of section 16006 of the 21st Century Cures Act uses "locum tenens arrangements" to refer to both fee-for-time compensation arrangements and reciprocal billing arrangements. As a result, continuing to use the term "locum tenens" to refer solely to fee-

for-time compensation arrangements is not consistent with the law and could be confusing to the public.

2. Update Chapter 1, Sections 30.2.1; 30.2.10; 30.2.11; 30.2.13; and 30.2.14 of the *Medicare Claims Processing Manual* by changing *Carriers* to *A/B MACs Part B* and removing all references to *UPIN* (since the terms carriers and UPIN are obsolete).
3. Update Chapter 1, Sections 30.2.10 and 30.2.11 of the *Medicare Claims Processing Manual* to clarify that when a regular physician or physical therapist is called or ordered to active duty as a member of a reserve component of the armed forces for a continuous period of longer than 60 days, payment may be made to that regular physician or physical therapist for services furnished by a substitute under reciprocal billing arrangements or fee-for-time compensation arrangements throughout that entire period. This policy is required by section 137 of the Medicare Improvements for Patients and Providers Act of 2008.

**Note:** The revised portions of Chapter 1, Section 30 of the *Medicare Claims Processing Manual* are included as an attachment to CR 10090.

### Q5 and Q6 Modifiers

MACs will accept claims from physical therapists, provider specialty 65 – physical therapist in private practice, for reciprocal billing arrangements, when submitted with the Q5 modifier. MACs will accept claims from physical therapists, provider specialty 65 – physical therapist in private practice, for fee-for-time compensation arrangements, when submitted with the Q6 modifier. MACs will accept claims from physical therapists that are reported with a Q5 or Q6 modifier whose descriptor references only physicians. When the descriptors are updated to include physical therapists and physicians, MACs will accept the Q5 or Q6 modifier with the updated descriptor.

**Note:** The Q5 and Q6 modifiers' descriptors will be amended to include physical therapists in addition to physicians in the near future in a HCPCS quarterly update.

### Additional information

The official instruction, CR 10090, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3774CP.pdf>.

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

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**Surgery**

**Office of Inspector General Report: Stem cell transplantation**

*Note: This article was revised on May 1, 2017, to make a number of clarifications and to delete the table that had been in the article. This information was previously published in the [December 2016 Medicare B Connection](#), pages 23-24.*

**Provider types affected**

This article is intended for providers billing Medicare administrative contractors (MACs) for services related to stem cell transplantation.

**Provider action needed**

The Office of the Inspector General (OIG) recently completed a review of Medicare claims related to stem cell transplants. This article is intended to address issues of incorrect billing as a result of the [February 2016 OIG report](#) and to clarify coverage of stem cell transplantation. This article does not introduce any new policies. It is intended to clarify the billing for stem cell services.

**Background**

The Centers for Medicare & Medicaid Services (CMS) has a coverage policy for stem cell transplantation, and the *Medicare National Coverage Determination (NCD) Manual (Publication 100-03, Section 110.8)* states that stem cell transplantation is a process in which stem cells are harvested from either a patient's or donor's bone marrow or peripheral blood for intravenous infusion.

**Types of stem cell transplants that are covered:**

Medicare covers allogeneic and autologous transplants. Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses.

**1. Allogeneic hematopoietic stem cell transplantation (HSCT)**

Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor's stem cells is obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect.

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

**2. Autologous stem cell transplantation (AuSCT)**

Autologous stem cell transplantation is a technique for restoring stem cells using the patient's own previously stored cells. Autologous stem cell transplants (AuSCT) must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high-dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

In its [February 2016 OIG report](#), the OIG determined that Medicare paid for many stem cell transplant procedures incorrectly. The main finding was that providers billed these procedures as inpatient when they should have been submitted as outpatient or outpatient with observation services. The key points in the report include:

- According to an independent medical review contractor contracted by OIG for this report, stem cell transplants are routinely performed in the outpatient setting.
- Hospitals may have incorrectly thought that stem cell transplantation was on CMS's list of inpatient-only procedures.

**The two-midnight rule**

To assist providers in determining whether inpatient admission is appropriate for payment under Medicare Part A, CMS adopted the two-midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria to use when determining whether an inpatient admission is reasonable and necessary for purposes of payment under Medicare Part A.

In general, the two-midnight rule states that:

- Inpatient admissions will generally be payable under Part A if the admitting practitioner expects the patient to require a hospital stay that crosses two midnights

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**BILLING**

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**Document history**

Date of change	Description
May 15, 2017	Initial article released.

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## OIG

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and the medical record supports that reasonable expectation.

- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.

The two-midnight rule also specifies that all treatment decisions for beneficiaries are based on the medical judgment of physicians and other qualified practitioners. The two-midnight rule does not prevent the physician or other qualified practitioner from providing any service at any hospital, regardless of the expected duration of the service.

As of 2016, for stays for which the physician or other qualified practitioner expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician or other qualified practitioner. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.

### Additional information

The OIG report is available at <https://oig.hhs.gov/oas/reports/region9/91402037.pdf>.

The section of the *National Coverage Determinations Manual* that deals with stem cell transplants for treatment of certain conditions is available at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1\\_Part2.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf).

You may want to review the following *MLN Matters*<sup>®</sup> articles for further information:

- MM9620 - “Stem Cell Transplantation for Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease, and Myelodysplastic Syndromes” is at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9620.pdf>.
- MM6416 - “April 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)” is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6416.pdf>.

- MM4173 - “Stem Cell Transplantation” is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4173.pdf>.
- MM3797 - “Updated Requirements for Autologous Stem Cell Transplantation (AuSCT) for Amyloidosis” is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3797.pdf>.

There is a fact sheet on the two-midnight rule at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-4.html>.

CMS provides further guidance on the two-midnight rule with responses to frequently asked questions at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting\\_110413-v2-CLEAN.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf).

Additional information is in a transcript of an MLN Connects<sup>®</sup> conference call discussing the two-midnight rule, which is available at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2-27-14MidnightRuleTranscript.pdf>.

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

### Document history

- November 22, 2017 - Initial article released.
- May 1, 2017 - The article was revised to make a number of clarifications and to delete the table that had been in the article.

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## Correct reporting of MSP type on electronic claims

Please take a few minutes to ensure you obtain Medicare secondary payer (MSP) insurance information and report the correct corresponding MSP type on your Medicare secondary claim submissions. **Effective for claims processed on or after April 27, 2017, failure to supply the correct MSP type will result in a return unprocessable claim (RUC) denial with claim adjustment reason code (CARC) code 16 and remittance advice remark code (RARC) N245.** These messages indicate the claim information was reported incorrectly and you must submit a new claim with the correct MSP type.

When submitting an electronic claim to Medicare, you are required to obtain MSP insurance information from the patient. The patient's insurance is classified as either a group health plan (GHP) or a non-group health plan (NGHP). Examples of GHP coverage are working aged (WA), disability, or end-stage renal disease (ESRD). These types of coverage are based on current or past employment. Examples of NGHP coverage are automobile/no-fault, workers' compensation (WC), and liability. These types of coverage are typically the result of an accident, injury, or lawsuit. Although there are other types of MSP coverage, these are the most common.

We receive many MSP claims with the incorrect insurance type reported. It is extremely important to report the correct MSP insurance type on a claim. Some examples of incorrect MSP insurance types are:

- Reporting MSP type 47 (liability) as a default code
- Reporting MSP type 12 (WA) instead of 43 (disability) or 13 (ESRD)

**Please reference the chart below for the two-digit MSP insurance type and a brief description of the MSP provision.**

MSP insurance type	GHP or NGHP	MSP provision
12	GHP	Working aged – Beneficiaries age 65 or older who are insured through their own or their spouse's current employment. The beneficiary must be aged 65 or older. There must be at least 20 or more employees.

MSP insurance type	GHP or NGHP	MSP provision
43	GHP	Disability – This coverage is for beneficiaries who are under age 65 and disabled. Insurance is based on their own current employment or through the current employment of a family member. There must be 100 or more employees.
13	GHP	End-stage renal disease – This coverage is for beneficiaries enrolled with Medicare solely due to renal failure and are insured through their own, or through a family member's current or former employment. Medicare is secondary payer for the first 30 months. There is no age restriction on this type of coverage. The beneficiary may be under or over age 65.
14	NGHP	Automobile/no-fault – No-fault insurance that pays for medical expenses for injuries sustained from a motor vehicle accident. This coverage is not based on employment.
15	NGHP	Workers' compensation – This is insurance that employers are required to provide employees that become ill or injured on the job.
47	NGHP	Liability – Insurance (including a self-insured plan) that provides payment based on the policyholder's alleged legal liability for injury, illness or damage to property. Some examples of this coverage could be product liability, malpractice, and homeowner's coverage.

For more information on how to submit electronic MSP claims and where to indicate the MSP type, please review [Billing the correct Medicare secondary payer insurance type code](#).

## QMB

From front page

from the beneficiary) as payment in full for services rendered to an individual enrolled in the QMB program.

CR 9911 aims to support Medicare providers' ability to meet these requirements by modifying the Medicare claim processing system to clearly identify the QMB status of all Medicare patients. Currently, neither the Medicare eligibility systems (the HIPAA eligibility transaction system (HETS)), nor the claim processing systems (the FFS shared systems), notify providers about their patient's QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare summary notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

CR 9911 includes modifications to the FFS claim processing systems and the *Medicare Claims Processing Manual* to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare's common working file (CWF) will obtain QMB indicators so the claim processing systems will have access to this information.

- CWF will provide the claims processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims; and outpatient institutional types of bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x); home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x, or 060x; and skilled nursing facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).
- CWF will provide the claim processing systems the QMB indicator if the "through date" falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the remittance advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with three new remittance advice remark codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

- N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

- N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

In addition, the MACs will include a claim adjustment reason code of 209 ("Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with group code OA (other adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

### Additional information

The official instruction, CR 9911, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3764CP.pdf>.

For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the *MLN Matters*<sup>®</sup> article, SE1128, at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf>.

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

### Document history

- **February 3, 2017** - Initial article released.
- **May 1, 2017** - The article was revised to reflect a revised CR 9911 issued April 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. All other information remains the same.

*MLN Matters*<sup>®</sup> Number: MM9911 *Revised*

Related Change Request (CR) #: CR 9911

Effective Date: For claims processed on or after October 2, 2017

Related CR Release Date: April 28, 2017

Related CR Transmittal #: R3764CP

Implementation Date: October 2, 2017

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## Prohibition on billing dually eligible individuals enrolled in the QMB program

**Note:** This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the qualified Medicare beneficiary (QMB) program. All other information is the same. This information was previously published in the [October 2011 Medicare B Connection](#), pages 28-29.

### Provider types affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in original Medicare or a Medicare advantage (MA) plan.

### What you need to know

#### Stop – impact to you

This special edition *MLN Matters*<sup>®</sup> article from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing**. QMB is a Medicare savings program (MSP) that exempts Medicare beneficiaries from Medicare cost-sharing liability.

#### Caution – what you need to know

The QMB program is a state Medicaid benefit that covers Medicare premiums and deductibles, coinsurance, and copayments, subject to state payment limits. States may limit their liability to providers for Medicare deductibles, coinsurance, and copayments under certain circumstances. Medicare providers may not bill QMB individuals for Medicare cost-sharing, regardless of whether the state reimburses providers for the full

Medicare cost-sharing amounts. Further, all original Medicare and MA providers--not only those that accept Medicaid--must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately bill QMB individuals are subject to sanctions.

#### Go – what you need to do

Refer to the *Background* and *Additional information* sections of this article for further details and resources about this guidance. Please ensure that you and your staff are aware of the federal billing law and policies regarding QMB individuals. Contact the Medicaid agency in the states in which you practice to learn about ways to identify QMB patients in your state and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a MA provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

### Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments.



### Billing of QMBs is prohibited by federal law

Federal law bars Medicare providers from billing a QMB beneficiary under any circumstances. See [Section 1902\(n\)\(3\)\(B\) of the Social Security Act \(the Act\)](#), as modified by [Section 4714 of the Balanced Budget Act of 1997](#).

QMB is a Medicaid program for Medicare beneficiaries that exempt them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who do not follow these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

### Inappropriate billing of QMB individuals persists

Despite federal law, improper billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to [Access to Care Issues Among Qualified Medicare Beneficiaries \(QMB\)](#), *Centers for Medicare & Medicaid Services July 2015*.

### Important clarifications concerning the QMB billing law

Be aware of the following policy clarifications to ensure compliance with QMB billing requirements.

1. All original Medicare and MA providers--not only those that accept Medicaid--must abide by the billing prohibitions.

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## PROHIBITION

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2. QMB individuals retain their protection from billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different state than the state in which care is rendered.
3. Note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the state Medicaid manual, which is no longer in effect.

### Ways to improve processes related to QMBs

Proactive steps to identify QMB individuals you serve and to communicate with state Medicaid agencies (and MA plans if applicable), can promote compliance with QMB billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients, such as finding out the cards that are issued to QMB individuals, so you can in turn ask all your patients if they have them. Learn if you can query state systems to verify QMB enrollment among your patients. MA providers should contact the plan to determine how to identify the plan's QMB enrollees. Beginning October 1, 2017, you will be able to readily identify the QMB status of your patients with new Medicare fee-for-services improvements. Refer to [Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System](#) for more information about these improvements.
2. Determine the billing processes that apply to seeking reimbursement for Medicare cost-sharing from the states in which you operate. Different processes may apply to original Medicare and MA services provided to QMB beneficiaries. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare benefits coordination & recovery center (BCRC) to automatically receive Medicare-adjudicated claims.
  - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare remittance advice.
  - Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your state. You may need to complete a state provider registration process and be entered into the state payment system to bill the state.
3. Ensure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

### QMB eligibility and benefits (see page 32)

\* States can effectively raise these Federal income and resources criteria under Section [1902\(r\)\(2\)](#) of the Act.



\*\*\* To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a "conditional basis"). For more information on this process, refer to Section HI 00801.140 of the [Social Security Administration Program Operations Manual System](#).

### Additional information

For more information about dual eligibles under Medicare and Medicaid, please visit <https://www.medicaid.gov/affordable-care-act/dual-eligibles/index.html> and <https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html> and refer to Dual Eligible Beneficiaries Under Medicare and Medicaid. For general Medicaid information, please visit <http://www.medicaid.gov/index.html>.

### Document history

Date of change	Description
May 12, 2017	This article was revised May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.
January 12, 2017	This article was revised to add a reference to <i>MLN Matters</i> ® article MM9817, which instructs Medicare administrative contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.
February 4, 2016	The article was revised February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 of "Important Clarifications Concerning QMB Balance Billing Law."
February 1, 2016	The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table.

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# PROHIBITION

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Release Date of Revised Article: May 12, 2017  
 Effective Date: N/A  
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 Implementation Date: N/A

Date of change	Description
March 28, 2014	The article was revised to change the name of the coordination of benefits contractor (COBC) to BCRC.

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MLN Matters® Number: SE1128 *Revised*  
 Related Change Request (CR) #: N/A

## MB eligibility and benefits

Program	Income criteria*	Resources criteria*	Medicare Part A and Part B enrollment	Other criteria	Benefits
QMB only	≤100% of federal poverty line (FPL)	≤3 times SSI resource limit, adjusted annually in accordance with increases in consumer price index	Part A***	Not applicable	<ul style="list-style-type: none"> <li>Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid state plan (even if payment is not available under the state plan for these charges, QMBs are not liable for them)</li> </ul>
QMB plus	≤100% of FPL	Determined by state	Part A***	Meets financial and other criteria for full Medicaid benefits	<ul style="list-style-type: none"> <li>Full Medicaid coverage</li> <li>Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid state plan (even if payment is not available under the state plan for these charges, QMBs are not liable for them)</li> </ul>

\* States can effectively raise these federal income and resources criteria under Section [1902\(r\)\(2\)](#) of the Act.

\*\*\* To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a “conditional basis”). For more information on this process, refer to Section HI 00801.140 of the [Social Security Administration Program Operations Manual System](#).

# New physician specialty code for advanced heart failure and transplant cardiology, medical toxicology, and hematopoietic cell transplantation and cellular therapy

## Provider types affected

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

## Provider action needed

Change request (CR) 9957 establishes new physician specialty codes for advanced heart failure and transplant cardiology (C7), medical toxicology (C8), and hematopoietic cell transplantation and cellular therapy (C9). The new codes are effective on October 1, 2017. Make sure that your billing staffs are aware of these new specialty codes.

## Background

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Medicare physician specialty codes describe the specific/unique types of medicine that physicians (and certain other suppliers) practice. The Centers for Medicare & Medicaid Services (CMS) uses specialty codes for programmatic and claim processing purposes.

The CMS-855I and CMS-855O paper applications will be updated to reflect the new specialties in the future. In the interim, providers shall select the 'Undefined physician type' option on the enrollment application and specify the applicable specialty in the space provided.

Existing enrolled providers who want to update their specialty to reflect one of the new specialties must submit a change of information application to their MAC. Providers may submit an enrollment application to initially enroll or

update their specialty within 60 days of the implementation date of the new specialties.

## Additional information

The official instruction, CR 9957, consists of two transmittals and updates two Medicare manuals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3762CP.pdf>. The second transmittal updates the Medicare Financial Management Manual and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R283FM.pdf>.

If you have any questions, please contact your MAC at their toll-free

number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

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 Effective Date: October 1, 2017  
 Related CR Transmittal #: R283FM and R3762CP  
 Implementation Date: October 2, 2017

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## CMS guidelines for prior authorization

**Note:** This article was revised May 1, 2017, to include a new web address for the required prior authorization list. All other information remains the same. This information was previously published in the [February 2017 Medicare B Connection](#), page 17-18.

### Provider types affected

This *MLN Matters*<sup>®</sup> article is intended for providers ordering certain DMEPOS items and suppliers submitting claims to Medicare administrative contractors (MACs) for items furnished to Medicare beneficiaries.

### What you need to know

Change request (CR) 9940 updates the Centers for Medicare & Medicaid Services (CMS) *Program Integrity Manual* to permit the MACs to conduct prior authorization processes, as so directed by CMS through individualized operational instructions. As of January 2017,

prior authorization of certain durable medical equipment, prosthetic, orthotic, and supply items, frequently subject to unnecessary utilization, is the only permanent (non-demonstration) prior authorization program approved for implementation. Make sure your billing staff is aware of these changes.

### Background

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted to a medical review contractor for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing. It is a process that permits the submitter/requester (for example, provider, supplier, beneficiary) to send in medical documentation, in advance of the item or service being rendered, and subsequently billed, in order to verify its eligibility for Medicare claim payment.

For any item or service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category
- Be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare coverage, coding and payment requirements

Contractors shall, at the direction of CMS or other authorizing entity, conduct prior authorizations and alert the requester/submitter of any potential issues with the information submitted.

A prior authorization request decision can be either a provisional affirmative or a non-affirmative decision.

- A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare's coverage, coding, and payment requirements.
- A non-affirmative decision is a finding that the submitted information/ documentation does not meet Medicare's coverage, coding, and payment

requirements, and if a claim associated with the prior authorization is submitted for payment, it would not be paid. MACs shall provide notification of the reason for the non-affirmation, if a request is non-affirmative, to the submitter/requester. If a prior authorization request receives a non-affirmative decision, the prior authorization request can be resubmitted an unlimited number of times.

- Prior authorization may also be a condition of payment. This means that claims submitted without an indication that the submitter/requester received a prior authorization decision (that is, unique tracking number (UTN)) will be denied payment.

Each prior authorization program will have an associated operational guide that will be available on the CMS website. In addition, MACs will educate stakeholders each time a new prior authorization program is launched. That education will include the requisite information and timeframes for prior authorization submissions and the vehicle to be used to submit such information to the MAC.

### Prior authorization program for DME MACs

A prior authorization program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items that are frequently subject to unnecessary utilization is described in 42 CFR 414.234. Among other things, this section establishes a master list of certain DMEPOS items meeting inclusion criteria and potentially subject to prior authorization. CMS will select Healthcare Common Procedure Coding System (HCPCS) codes from the prior authorization master list to be placed on the required prior authorization list, and such codes will be subject to prior authorization as a condition of payment. In selecting HCPCS codes, CMS may consider factors such as geographic location, item utilization or cost, system capabilities, administrative burden, emerging trends, vulnerabilities identified in official agency reports, or other data analysis.

- The prior authorization master list is the list of DMEPOS items that have been identified using the inclusion criteria described in 42 CFR 414.234.
- The list of required DMEPOS prior authorization items contains those items selected from the prior authorization master list to be implemented in the prior authorization program. The list of required DMEPOS prior authorization items will be updated as additional codes are selected for prior authorization.
- CMS may suspend prior authorization requirements generally or for a particular item or items at any time and without undertaking rulemaking. CMS provides notification of the suspension of the prior authorization requirements via *Federal Register* notice and posting on the CMS prior authorization website.

The items on the required prior authorization list, a "CMS Final Rule 6050-F" subpage containing the master list, as well as other pertinent information and supporting documents regarding this program, are available at <https://>

See **PRIOR**, next page

## Issue identified with certain remittance advices

First Coast Service Options, Inc. (First Coast) has identified an issue with remittance advices that were issued for claims processed January 1, 2017, through February 9, 2017. Specifically, remittance advices for claims processed from January 1, 2017, through February 9, 2017, that met all of the criteria below displayed the incorrect payment reduction amounts.

- When the Physician Quality Reporting System (PQRS), Electronic Health Records (EHR), and/or ambulatory surgical center (ASC) quality reporting payment reductions were applied and the service had a quantity billed greater than one and the procedure code has a multiple procedure payment reduction (MPPR) indicator other than one.

**Note:** The MPPR indicator can be located using the fee schedule lookup tool. The fee schedule lookup tool – help guide can assist in utilizing the lookup tool and locating the MPPR indicator.

Although the impacted remittances are showing a higher



amount for the reductions than what was truly taken on the claims, the actual payment amount is correct. This issue was caused by a recent update to Medicare’s internal processing system and was corrected February 10, 2017. First Coast will not adjust the impacted claims to produce corrected remittances, but wants to assure you that the correct payments have been issued for these claims.

### PRIOR

previous page

[www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html).

### Additional information

The official instruction, CR 9940, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R698PI.pdf>.

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

### Document history

- January 20, 2017 - Initial article released.
- May 1, 2017 - Article revised to include new web address for the required prior authorization list. All other information remains the same.

MLN Matters® Number: MM9940 *Revised*  
 Related Change Request (CR) #: CR 9940  
 Related CR Release Date: January 20, 2017  
 Effective Date: February 21, 2017  
 Related CR Transmittal #: R698PI  
 Implementation Date: February 21, 2017

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### Find out first: Subscribe to First Coast eNews

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# Updated manual guidelines for EFT payments and change of ownership

## Provider type affected

This *MLN Matters*<sup>®</sup> article is intended for providers involved in a change of ownership (CHOW) submitting claims to Part A & B Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

## Provider action needed

Special edition article SE17012 clarifies language in Chapter 15, Section 15.7.7.1.5 of the *Medicare Program Integrity Manual* related to electronic funds transfer (EFT) payments and changes of ownership (CHOWs). Please make sure your staffs are aware of this update.

## Background

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 9953 (effective May 15, 2017), for the purpose of making revisions to Chapter 15, Section 15.7.7.1.5 (Electric Funds Transfer (EFT) Payments and CHOWs) of the *Medicare Program Integrity Manual*. The revisions explain that after a CHOW has been processed, only the buyer is permitted to submit claims.

CHOW is defined in 42 CFR 489.18 (a) and generally means, in the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable state law. In the case of a corporation, the term generally means the merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. The transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.

The most common example of a CHOW occurs when a provider's CMS certification number (CCN) and provider agreement is transferred to another entity as a result of the latter's purchase of the provider. To illustrate, suppose entity A is enrolled in Medicare, but entity B is not. B acquires A. Assuming all regulatory requirements are met, A's provider agreement and CCN number will transfer to B.

Upon accepting the provider agreement, the new owner accepts the terms and conditions under which it was originally issued. Once the CHOW processes and the MAC: 1) receives the tie-in notice from the CMS regional office; and 2) updates the Provider Enrollment Chain and Ownership System (PECOS), claims will only be paid under the new owner's tax identification number, national provider identifier and CCN, or provider transaction number.

MACs will no longer have the ability to update the crosswalk in order for the Seller to complete their billing. Therefore, the old and new owners are responsible for working together on payment arrangements for claims for services furnished during and before the CHOW is processed.

The updated manual language follows:

### PIM language update

In a CHOW, the existing provider agreement is

automatically assigned to the buyer/transferee. If the buyer/transferee does not explicitly reject automatic assignment before the transfer date, the provider agreement is automatically assigned, along with the CCN, effective on the transfer date. The assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued. Among other things, this means that the contractor will continue to adjust payments to the provider to account for prior overpayments and underpayments, even if they relate to services provided before the sale/transfer. If the buyer rejects assignment of the provider agreement, the buyer must file an initial application to participate in the Medicare program. In this situation, Medicare will never pay the applicant for services the prospective provides before the date on which the provider qualifies for Medicare participation as an initial applicant.

Depending on the terms of the sale, the buyer/transferee may obtain a new NPI or maintain the existing NPI. After CHOW processing is complete, the seller/transferee will no longer be allowed to bill for services (i.e., services furnished after CHOW processing is complete) and only the buyer is permitted to submit claims using the existing CCN. It is ultimately the responsibility of the old and new owners to work out between themselves any payment arrangements for claims for services furnished during the CHOW processing period.

## Additional information

The official instruction, CR 9953, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R715PI.pdf>.

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

## Document history

Date of change	Description
May 16, 2017	Initial article released.

*MLN Matters*<sup>®</sup> Number: SE17012  
 Related Change Request (CR) Number: 9953  
 Article Release Date: May 16, 2017  
 Effective Date: May 15, 2017  
 Related CR Transmittal Number: R715PI  
 Implementation Date: May 15, 2017

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

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

### Effective and notice dates

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

### Electronic notification

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

### More information

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

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



## Looking for LCDs?

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

## Advance beneficiary notice

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

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

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

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

## Before you file an appeal...

Each month, thousands of medical providers send written inquiries to First Coast Service Options Inc. (First Coast) to check the status of an appealed claim. Unfortunately, many of these appeals and subsequent inquiries are submitted on claims that were ineligible for appeal.

Before you appeal a denied claim, check out [these resources](#).



## Retired LCD

## Implantable miniature telescope (IMT) – retired Part A and Part B LCD

**LCD ID number: L33377 (Florida, Puerto Rico/ U.S. Virgin Islands)**

Based on data analysis review of the implantable miniature telescope (IMT) local coverage determination (LCD), it was determined that this LCD is no longer required and, therefore, is being retired.

### Effective date

The retirement of this LCD is effective for services rendered **on or after May 10, 2017**.



First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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

**Note:** To review active, future and retired LCDs, please [click here](#).

## Multiple Part A and Part B local coverage determinations being retired

**LCD ID number: L33987, L34000, L33708, L33596, L34020 (Florida, Puerto Rico/U.S. Virgin Islands)**

Based on data analysis review of the following local coverage determinations (LCDs), it was determined that these LCDs are no longer required and, therefore, are being retired.

L33987 – Computerized Dynamic Posturography

L34000 – Ganciclovir and Cidofovir

L33708 – Plerixafor (Mozobil®)

L33596 – Qutenza (capsaicin) 8% patch

L34020 – Sargramostim (GM-CSF, Leukine®)

### Effective date

The retirement of these LCDs is effective for services rendered **on or after May 10, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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

**Note:** To review active, future and retired LCDs, please [click here](#).

## Multiple Part B local coverage determinations being retired

**LCD ID number: L33807, L33902, L33928 (Florida, Puerto Rico/U.S. Virgin Islands)**

Based on data analysis review of the following local coverage determinations (LCDs), it was determined that these LCDs are no longer required and, therefore, are being retired.

L33807 – Caspofungin acetate (Cancidas®)

L33902 – Comprehensive Motion Analysis Studies

L33928 – Osteogenic Stimulation

### Effective date

The retirement of these LCDs is effective for services rendered **on or after May 10, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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

**Note:** To review active, future and retired LCDs, [click here](#).

## Revisions to LCD

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

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

**Effective date**

The local coverage determination (LCD) for gemcitabine (Gemzar®) was revised to add the indication “cancers of the nasopharynx” to the “Off label indications” section of the LCD.

Also, the ICD-10-CM codes C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C14.0, C14.2, C30.0, D37.05, Z85.21, Z85.22, Z85.810, Z85.818, and Z85.819 were added to the “ICD-10 Codes that Support Medical Necessity” section of the LCD for Healthcare Common Procedure

Coding System (HCPCS) code J9201. In addition, the “Sources of Information and Basis for Decision” section of the LCD was updated.



This LCD revision is effective for services rendered **on or after May 16, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

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

**Note:** To review active, future and retired LCDs, please [click here](#).



### Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

### Medicare Learning Network®

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





## Upcoming provider outreach and educational events

### Medicare Part B changes and regulations

**Date:** Wednesday, June 14

**Time:** 11:30 a.m.-1:00 p.m.

**Type of Event:** Webcast

<https://medicare.fcso.com/Events/0369645.asp>

### Medicare Part A/B changes and regulations

**Date:** Wednesday, June 14

**Time:** 11:30-1:00 p.m.

**Type of Event:** Webcast

<https://medicare.fcso.com/Events/0372840.asp>

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

### Two easy ways to register

**Online** – Visit our provider training website at <http://www.fcsouniversity.com>, log on to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event.

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

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

#### Please Note:

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

Registrant’s Name: \_\_\_\_\_

Registrant’s Title: \_\_\_\_\_

Provider’s Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

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

### Never miss a training opportunity

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

### Take advantage of 24-hour access to free online training

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



The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*<sup>®</sup> is an official *Medicare Learning Network*<sup>®</sup> (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 e-News to their membership as appropriate.

## MLN Connects<sup>®</sup> for April 27, 2017

*MLN Connects<sup>®</sup> for April 27, 2017*

[View this edition as a PDF](#) 

### News & Announcements

- Clinicians: MIPS Participation Status Letter
- Open Payments Program Year 2016 Review and Dispute Period Ends May 15
- EHR Incentive Programs: Submit Comments on Proposed Changes by June 13
- IMPACT Act Data Elements Public Comments Due June 26
- IRF Quality Reporting Program Review and Correct Reports Available
- Quality Payment Program: New Videos for Small, Rural, and Underserved Practices
- EHR Incentive Programs: Public Health Agency and Clinical Data Registry Reporting
- Updated Advance Beneficiary Notice
- Antipsychotic Drug use in Nursing Homes: Trend Update
- April is STD Awareness Month: Talk, Test, Treat

### Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities

### Upcoming Events

- IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2
- Comparative Billing Report on Transitional Care Management Webinar — June 21

### Claims, Pricers & Codes

- Hospitals and SNFs: Claims Hold Related to VA Claims



### Medicare Learning Network<sup>®</sup> Publications & Multimedia

- Next Generation ACO – All Inclusive Population Based Payment Implementation *MLN Matters*<sup>®</sup> Article — New
- Open Payments Call: Audio Recording and Transcript — New
- Medicare Home Health Benefit Web-Based Training Course — Revised
- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised
- Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Revised
- PECOS FAQs Booklet — Reminder

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## MLN Connects® Special Edition – Friday, April 28, 2017

### In This Edition:

1. Skilled Nursing Facilities: Proposed FY 2018 Payment and Policy Changes
2. Inpatient Rehabilitation Facilities: Proposed FY 2018 Payment and Policy Changes
3. Medicare Hospice Benefit: Proposed FY 2018 Updates to the Wage Index and Payment Rates

### Skilled Nursing Facilities: Proposed FY 2018 Payment and Policy Changes

CMS issued a proposed rule (CMS-1679-P) outlining proposed FY 2018 Medicare payment rates and quality programs for Skilled Nursing Facilities (SNFs). Additionally, CMS released an Advance Notice of Proposed Rulemaking (CMS-1686-ANPRM), which solicits comment on potential revisions to the SNF payment system, based on research conducted under the SNF Payment Models Research project.

#### Proposed Rule Details:

- Changes to payment rates under the SNF Prospective Payment System (PPS)
- SNF Quality Reporting Program
- SNF Value-Based Purchasing (VBP) Program
- End-Stage Renal Disease Quality Incentive Program
- Request for Information
- Survey team composition

#### For More Information:

- [Proposed Rule](#): CMS will accept comments until June 26
- [Advanced Notice of Proposed Rulemaking](#): CMS will accept comments until June 26
- [SNF PPS Payment Model Research](#) web page
- [SNF PPS](#) website
- [SNF QRP](#) website
- [SNF VBP](#) Program website

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

### Inpatient Rehabilitation Facilities: Proposed FY 2018 Payment and Policy Changes

CMS issued a proposed rule (CMS-1671-P) outlining proposed FY 2018 Medicare payment policies and rates for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program (QRP). In addition to the proposed rule, CMS is releasing a Request for Information to welcome continued feedback on the Medicare Program.

#### Proposed Rule Details:

- Proposed updates to IRF payment rates
- Proposed removal of 25 percent payment penalty for late transmissions of the IRF- Patient Assessment Instrument
- Proposed refinements to the 60 percent rule presumptive methodology



- Solicitation of comments regarding the criteria used to classify facilities for payment under the IRF PPS
- Proposed technical IRF process revisions
- Proposed changes to the IRF QRP

#### For More Information:

- [Proposed Rule](#) CMS will accept comments until June 26

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

### Medicare Hospice Benefit: Proposed FY 2018 Updates to the Wage Index and Payment Rates

CMS issued a proposed rule (CMS-1675-P) that would update FY 2018 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries and releases Request for Information within the proposed rule. This proposed rule would update the hospice wage index, payment rates, and cap amount for FY 2018.

#### Proposed Rule Details:

- Routine annual rate setting changes
- Discussion and solicitation of comments regarding sources of clinical information for certifying terminal illness
- Hospice CAHPS® Experience of Care Survey
- Quality measure concepts under consideration for future years
- New data collection mechanisms under consideration: Hospice Evaluation & Assessment Reporting Tool (HEART)
- Public reporting

#### For More Information:

- [Proposed rule](#): CMS will accept comments until June 26
- [Hospice Center](#) web page

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

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## MLN Connects® for May 4, 2017

*MLN Connects® for May 4, 2017*

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### News & Announcements

- DMEPOS Revised Blended Fee Schedule Amounts
- TEP on SNF QRP Development and Maintenance of Quality Measures: Nominations due May 12
- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
- MIPS: Submit Measures for the Advancing Care Information Performance Category by June 30
- Hospice Item Set V2.00.0 Receives OMB Approval
- EHR Incentive Programs: Review 2017 Program Requirements
- Hand Hygiene Day is May 5

### Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly

### Upcoming Events

- MIPS Group Reporting 101 Webinar — May 11

## MLN Connects® for May 11, 2017

*MLN Connects® for May 11, 2017*

[View this edition as a PDF](#) 

### News & Announcements

- Open Payments Program Year 2016 Review and Dispute Period Ends May 15
- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
- Lookup Tool to Help Determine MIPS Participation Status
- Updated CY 2018 eCQM Specifications Available
- New PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
- Requesting Appeal Redeterminations
- National Women's Health Week Kicks off on Mother's Day



### Medicare Learning Network® Publications & Multimedia

- Medicare Shared Savings Program Call: Audio Recording and Transcript — New
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Web-Based Training Course — Revised
- Medicare Ambulance Transports Booklet — Revised
- Looking for the Latest National Medicare Policy Information?

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### Provider Compliance

- CMS Provider Minute Video: Coudé Tip Catheters

### Medicare Learning Network® Publications & Multimedia

- Global Surgery Call: Audio Recording and Transcript — New
- Emergency Preparedness Call: Audio Recording and Transcript — New
- Resources for Medicare Beneficiaries Booklet — Revised
- SNF Billing Reference Booklet — Revised
- Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Revised

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## MLN Connects® for May 18, 2017

MLN Connects® for May 18, 2017

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### News & Announcements

- Clinical Laboratories: Lab Data Due May 30
- SNF Quality Reporting Program: Submission Deadline Extended to June 1
- National Mental Health Awareness Month 2017

### Provider Compliance

- Reporting Changes in Ownership

### Claims, Pricers & Codes

- 2018 ICD-10-PCS Files Available

### Upcoming Events

- Quality Payment Program Participation Criteria Webinar – May 22
- National Partnership to Improve Dementia Care and QAPI Call – June 15

### Medicare Learning Network® Publications & Multimedia

- Updated Manual Guidelines for Electronic Funds Transfer Payments and Change of Ownership MLN Matters Article – New



- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article – Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-Based Training Course – Reminder

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## Quarterly provider update

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

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

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

## Phone numbers

### Customer service

866-454-9007  
877-660-1759 (speech and hearing impaired)

### Education event registration hotline

904-791-8103 (NOT toll-free)

### Electronic data interchange (EDI)

888-670-0940

### Electronic funds transfers (EFT) (CMS-588)

866-454-9007  
877-660-1759 (TTY)

### Fax number (for general inquiries)

904-361-0696

### Interactive voice response (IVR) system

877-847-4992

### Provider enrollment

866-454-9007  
877-660-1759 (TTY)

### The SPOT help desk

855-416-4199  
email: [FCSOSPOTHelp@FCSO.com](mailto:FCSOSPOTHelp@FCSO.com)

## Addresses

### Claims

Medicare Part B Claims  
P.O. Box 2525  
Jacksonville, FL 32231-0019

### Redeterminations

Medicare Part B Redetermination  
P.O. Box 2360  
Jacksonville, FL 32231-0018

### Redetermination of overpayments

Overpayment Redetermination, Review Request  
P.O. Box 45248  
Jacksonville, FL 32232-5248

### Reconsiderations

C2C Innovative Solutions, Inc.  
Part B QIC South Operations  
ATTN: Administration Manager  
P.O. Box 183092  
Columbus, Ohio 43218-3092

### General inquiries

General inquiry request  
P.O. Box 2360  
Jacksonville, FL 32231-0018

Email: [FloridaB@fcso.com](mailto:FloridaB@fcso.com)  
Online form: <http://medicare.fcso.com/Feedback/161670.asp>

### Provider enrollment

Provider Enrollment  
P.O. Box 44021  
Jacksonville, FL 32231-4021

### Medical policy

Medical Policy and Procedure  
P.O. Box 2078  
Jacksonville, FL 32231-0048  
Email: [medical.policy@fcso.com](mailto:medical.policy@fcso.com)

### Medicare secondary payer

Medicare Part B Secondary Payer Dept.  
P.O. Box 44078  
Jacksonville, FL 32231-4078

### Electronic data interchange (EDI)

Medicare EDI  
P.O. Box 44071  
Jacksonville, FL 32231-4071

### Overpayments

Medicare Part B Debt Recovery  
P.O. Box 44141  
Jacksonville, FL 32231-4141

### Medicare Education and Outreach

Medicare Education and Outreach  
P.O. Box 45157  
Jacksonville, FL 32232-5157

### Fraud and abuse

Fraud and abuse complaints  
P.O. Box 45087  
Jacksonville, FL 32232-5087

### Freedom of Information Act requests

FOIA Florida  
P.O. Box 45268  
Jacksonville, FL 32232-5268

### Overnight mail and/or special courier service

First Coast Service Options Inc.  
532 Riverside Avenue  
Jacksonville, FL 32202-4914

## Websites

### Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor  
<http://medicare.fcso.com>

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services  
<https://www.cms.gov>

First Coast University  
<http://www.fcsouniversity.com/>

### Beneficiaries

Centers for Medicare & Medicaid Services  
<https://www.medicare.gov>



## Phone numbers

### Customer service

866-454-9007

877-660-1759 (speech and hearing impaired)

### Education event registration hotline

904-791-8103 (NOT toll-free)

### Electronic data interchange (EDI)

888-670-0940

### Electronic funds transfers (EFT) (CMS-588)

866-454-9007

877-660-1759 (TTY)

### Fax number (for general inquiries)

904-361-0696

### Interactive voice response (IVR) system

877-847-4992

### Provider enrollment

888-845-8614

877-660-1759 (TTY)

### The SPOT help desk

855-416-4199

Email: [FCSOSPOTHelp@FCSO.com](mailto:FCSOSPOTHelp@FCSO.com)

## Addresses

### Claims

Medicare Part B Claims

P.O. Box 45098

Jacksonville, FL 32232-5098

### Redeterminations

Medicare Part B Redetermination

P.O. Box 45024

Jacksonville, FL 32232-5024

### Redetermination of overpayments

First Coast Service Options Inc.

P.O. Box 45091

Jacksonville, FL 32232-5091

### Reconsiderations

C2C Innovative Solutions, Inc.

Part B QIC South Operations

ATTN: Administration Manager

P.O. Box 183092

Columbus, Ohio 43218-3092

### General inquiries

First Coast Service Options Inc.

P.O. Box 45098

Jacksonville, FL 32232-5098

Email: [askFloridaB@fcsso.com](mailto:askFloridaB@fcsso.com)

Online form: <http://medicare.fcsso.com/Feedback/161670.asp>

### Provider enrollment

Provider Enrollment

P.O. Box 44021

Jacksonville, FL 32231-4021

### Medical policy

Medical Policy and Procedure

P.O. Box 2078

Jacksonville, FL 32231-0048

Email: [medical.policy@fcsso.com](mailto:medical.policy@fcsso.com)

### Medicare secondary payer

Medicare Part B Secondary Payer Dept.

P.O. Box 44078

Jacksonville, FL 32231-4078

### Electronic data interchange (EDI)

Medicare EDI, 4C

P.O. Box 44071

Jacksonville, FL 32231-4071

### Overpayments

Medicare Part B Debt Recovery

P.O. Box 44141

Jacksonville, FL 32231-4141

### Medicare Education and Outreach

Medicare Education and Outreach

P.O. Box 45157

Jacksonville, FL 32232-5157

### Fraud and abuse

Fraud and abuse complaints

P.O. Box 45087

Jacksonville, FL 32232-5087

### Freedom of Information Act requests

FOIA USVI

P.O. Box 45073

Jacksonville, FL 32231-5073

### Special courier service

First Coast Service Options Inc.

532 Riverside Avenue

Jacksonville, FL 32202-4914

## Websites

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<http://www.cms.gov>

First Coast University

<http://www.fcsouniversity.com/>

### Beneficiaries

Centers for Medicare & Medicaid Services

<https://www.medicare.gov>

## Phone numbers

### Customer service

1-877-715-1921  
1-888-216-8261 (speech and hearing impaired)

### Education event registration hotline

904-791-8103 (NOT toll-free)  
904-361-0407 (FAX)

### Electronic data interchange (EDI)

888-875-9779

### Electronic funds transfers (EFT) (CMS-588)

877-715-1921  
877-660-1759 (TTY)

### General inquiries

877-715-1921  
888-216-8261 (TTY)

### Interactive voice response (IVR) system

877-847-4992

### Provider enrollment

877-715-1921  
877-660-1759 (TTY)

### The SPOT help desk

855-416-4199  
email: [FCSOSPOTHelp@FCSO.com](mailto:FCSOSPOTHelp@FCSO.com)

## Addresses

### Claims

Medicare Part B Claims  
P.O. Box 45036  
Jacksonville, FL 32232-5036

### Redeterminations

Medicare Part B Redetermination  
P.O. Box 45056  
Jacksonville, FL 32232-5056

### Redetermination of overpayments

First Coast Service Options Inc.  
P.O. Box 45015  
Jacksonville, FL 32232-5015

### Reconsiderations

C2C Innovative Solutions, Inc.  
Part B QIC South Operations  
ATTN: Administration Manager  
P.O. Box 183092  
Columbus, Ohio 43218-3092

### General inquiries

First Coast Service Options Inc.  
P.O. Box 45098  
Jacksonville, FL 32232-5098

Email: [askFloridaB@fcsso.com](mailto:askFloridaB@fcsso.com)  
Online form: <http://medicare.fcsso.com/Feedback/161670.asp>

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Provider Enrollment  
P.O. Box 44021  
Jacksonville, FL 32231-4021

### Medical policy

Medical Policy and Procedure  
P.O. Box 2078  
Jacksonville, FL 32231-0048  
Email: [medical.policy@fcsso.com](mailto:medical.policy@fcsso.com)

### Medicare secondary payer

Medicare Part B Secondary Payer Dept.  
P.O. Box 44078  
Jacksonville, FL 32231-4078

### Electronic data interchange (EDI)

Medicare EDI, 4C  
P.O. Box 44071  
Jacksonville, FL 32231-4071

### Overpayments

Medicare Part B Debt Recovery  
P.O. Box 45040  
Jacksonville, FL 32231-5040

### Medicare Education and Outreach

Medicare Education and Outreach  
P.O. Box 45157  
Jacksonville, FL 32232-5157

### Fraud and abuse

Fraud and abuse complaints  
P.O. Box 45087  
Jacksonville, FL 32232-5087

### Freedom of Information Act requests

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P.O. Box 45092  
Jacksonville, FL 32232-5092,

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532 Riverside Avenue  
Jacksonville, FL 32202-4914

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Find your *other contractors* (e.g. DME, HHA, etc)

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<https://www.cms.gov>

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<http://www.fcsouniversity.com/>

### Beneficiaries

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