

# C Medicare B CONNECTION

medicare.fcso.com



A Newsletter for MAC Jurisdiction N Providers

August 2017



## In this issue

Update to 2017 codes used for SNF consolidated billing enforcement .....	7
October 2017 quarterly ASP Medicare Part B drug pricing .....	8
Quarterly influenza virus vaccine code update – January 2018 .....	17
Updated editing of always therapy services .....	18
New search capability simplifies LCD lookup .....	26

## Suppression of the SPR in 45 days if also receiving electronic remittance advice

### Provider types affected

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

### Provider action needed

Change request (CR) 10151 provides notice that beginning January 2, 2018, Medicare's shared system maintainers (SSMs) must eliminate issuance of standard paper remittance advice (SPRs) to those providers/suppliers (or a billing agent, clearinghouse, or other entity representing those providers/suppliers) who also have been receiving electronic remittance advice (ERA) transactions for 45 days or more. The shared system changes to suppress the distribution of SPRs were implemented in January 2006 per CR 3991 (issued August 12, 2005, Transmittal 645). Make sure your billing staffs are aware of the suppression of the SPR.

### Background

The SPR is the hard copy version of an ERA. MACs, including durable medical equipment (DME) MACs must be capable of producing SPRs for providers/suppliers who are unable or choose not to receive an ERA. The MACs and the DME MACs suppress distribution of SPRs if an electronic data interchange (EDI) enrolled provider/supplier is also receiving ERAs for more than 31 days for institutional health care claims (837I) and 45 days for DME and professional health care claims (837P). Internet-only-manuals (IOMs), *MLN Matters*® article MM4376 provided information to the MACs regarding the receipt of SPR and ERA distribution time lines.

Beginning February 14, 2018, the SSMs shall suppress the delivery of SPR to the MACs EDI enrolled providers/suppliers who are also receiving both the ERA and SPR. In rare situations (such as natural or man-made disasters) exceptions to this policy may be allowed at the discretion of the Centers for Medicare & Medicaid Services (CMS).

See ERA, page 23



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

<b>About the Medicare B Connection</b>	
About the <i>Medicare B Connection</i> .....	3
Advance beneficiary notices.....	4
<b>Coverage/Reimbursement</b>	
<b>Cardiac Services</b>	
National coverage determination leadless pacemakers.....	5
<b>Consolidated Billing</b>	
October update to 2017 codes used for SNF consolidated billing enforcement.....	7
<b>Drugs &amp; Biologicals</b>	
October 2017 quarterly ASP Medicare Part B drug pricing files and revisions to prior files.....	8
<b>Durable Medical Equipment</b>	
July quarterly update for 2017 DMEPOS fee schedule.....	9
<b>Laboratory/Pathology</b>	
CMS updates list of new CLIA waived tests.....	10
<b>Preventive Services</b>	
Screening for hepatitis B virus infection.....	12
Quarterly influenza virus vaccine code update – January 2018.....	17
<b>Therapy Services</b>	
Updated editing of always therapy services.....	18
<b>Surgery</b>	
Percutaneous image-guided lumbar decompression for lumbar spinal stenosis.....	20
<b>General Coverage</b>	
ICD-10 coding revisions to national coverage determinations.....	21
New advance beneficiary notice required for use by August 21.....	22
Billing for certain new biosimilar biological products before the modifier is implemented.....	22
<b>General Information</b>	
NGACO year three benefit enhancements.....	23
QMB indicator in the Medicare FFS claim processing system.....	24
New search capability simplifies LCD lookup.....	26
<b>Local Coverage Determinations</b>	
Looking for LCDs?.....	27
Advance beneficiary notice.....	27
<b>Retired LCDs</b>	
Chelation therapy.....	28
Intraoperative neurophysiology monitoring.....	28
Low density lipoprotein (LDL) apheresis.....	28
<b>Revisions to LCDs</b>	
Label and off-label coverage of outpatient drugs and biologicals.....	29
Quarterly provider update.....	29
<b>Educational Resources</b>	
Upcoming provider outreach and educational events.....	30
<b>CMS MLN Connects®</b>	
July 27, 2017.....	31
CMS National Provider Enrollment Conference – September 6-7, 2017.....	31
August 3, 2017.....	32
August 10, 2017.....	32
August 17, 2017.....	33
<b>Contact Information</b>	
Florida Contact Information.....	34
U.S. Virgin Islands Contact Information.....	35
Puerto Rico Contact Information.....	36
<b>Order Form</b>	
Medicare Part B materials.....	37

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.

**Publication staff:**

Marielba Cancel  
Terri Drury  
Maria Murdoch  
Mark Willett  
Robert Petty

Fax comments about this publication to:

**Medicare Publications**  
904-361-0723

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.

*CPT® five-digit codes, descriptions, and other data only are copyright 2016 by American Medical Association (or such other date of publication of CPT®). All Rights Reserved. Applicable FARS/DFARS apply. No fee schedules, basic units, relative values or related listings are included in CPT®. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein.*

*ICD-10-CM codes and its descriptions used in this publication are copyright 2016 Optum360, LLC. All rights reserved.*

*This document contains references to sites operated by third parties. Such references are provided for your convenience only. Florida Blue and/or First Coast Service Options Inc. do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.*

*All stock photos used are obtained courtesy of a contract with www.shutterstock.com.*

## 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 <https://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>.

**Note:** New advance beneficiary notice required for use by August 21. See page 22 of this edition for details.



### 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.

Cardiac Services

National coverage determination leadless pacemakers

Provider type affected

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

Provider action needed

Change request (CR) 10117 informs MACs that effective January 18, 2017, the Centers for Medicare & Medicaid Services (CMS) covers leadless pacemakers through coverage with evidence development (CED) when procedures are performed in CMS-approved CED studies. Please make your billing staffs aware of this determination.

Background

The leadless pacemaker eliminates the need for a device pocket and insertion of a pacing lead which are integral elements of traditional pacing systems. The removal of these elements eliminates an important source of complications associated with traditional pacing systems while providing similar benefits. Leadless pacemakers are delivered via catheter to the heart, and function similarly to other transvenous single-chamber ventricular pacemakers. Prior to January 18, 2017, there was currently no national coverage determination (NCD) in effect.

On January 18, 2017, CMS issued an NCD to cover leadless pacemakers through CED. CMS covers leadless pacemakers when procedures are performed in studies approved by the Food & Drug Administration (FDA). CMS also covers, in prospective longitudinal studies, leadless pacemakers that are used in accordance with the FDA-approved label for devices that have either:

- An associated ongoing FDA-approved post-approval study; or
- Completed an FDA post-approval study.

For such coverage, Medicare will allow payment for claims for dates of service on or after January 18, 2017, for leadless pacemakers through CED when billed with the following CPT<sup>®</sup> codes:

- 0387T – Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular
- 0389T – Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system.
- 0390T – Peri-procedural device evaluation (in person) and programming of device system parameters before or after surgery, procedure or test with analysis, review and report, leadless pacemaker system.



- 0391T – Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system.

Effective for dates of service on or after January 18, 2017, MACs will allow the following ICD-10 diagnosis codes on claims for leadless pacemakers:

- Z00.6 – Encounter for examination for normal comparison and control in clinical research program.

Effective for dates of service on or after January 18, 2017, contractors shall return claims as unprocessable with the listed procedure codes billed without ICD-10 Z00.6 and use the following messages:

- CARC 16 -Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC M76 -Missing/incomplete/invalid diagnosis or condition

Effective for claims with dates of service on or after January 18, 2017, modifier **Q0** – Investigational clinical service provided in a clinical research study that is an approved clinical research study, must also be included.

Effective for dates of service on or after January 18, 2017, MACs will return claims with the procedure codes listed billed without modifier Q0 and use the following messages:

- CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N572: This procedure not payable unless appropriate non-payable reporting.

See **NCD**, next page

## NCD

previous page

- Group code – contractual obligation (CO).

Remember to include the eight-digit clinical trial identifier on the claim. Effective for claims with dates of service on or after January 18, 2017, MACs will return claims as unprocessable that are billed with the Q0 modifier and do not contain the eight-digit clinical trial identifier in item 23 of the CMS-1500 form or the electronic equivalent. Use the following messages:

- CARC 16: “Claim/service lacks information which is needed for adjudication At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)”
- RARC MA50: Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.
- Group Code – Contractual Obligation (CO).

Effective for dates of service in or after January 18, 2017, MACs shall only pay claims for leadless pacemakers when services are provided in one of the following places of service (POS):

- POS 06 – Indian health service provider based facility
- POS 21 – Inpatient hospital
- POS 22 – On campus-outpatient hospital
- POS 26 – Military treatment facility

Where the proper POS code is not included and the claim is rejected/denied, the following messaging should be used:

- CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. **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.hhs.gov/mcd/search.asp](http://www.cms.hhs.gov/mcd/search.asp). If you do have web access, you may contact the contractor to request a copy of the NCD.
- Group code – contractual obligation (CO)

MACs will not search their files for claims for leadless pacemakers with dates of service between January 18, 2017, and the implementation date of CR 10117, but may adjust claims that you bring to their attention.

All clinical research study protocols must address pre-specified research questions, adhere to standards of

scientific integrity and be reviewed and approved by CMS. Approved studies will be posted to the CMS website at <https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index.html>. The process for submitting a clinical research study to Medicare is outlined in the NCD.

Leadless pacemakers are non-covered outside of CMS-approved studies.

**Note:** This revision to the *Medicare NCD Manual* is a national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, and MACs with the federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent MACs, 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).

### Additional information

The official instruction, CR 10117, issued to your MAC regarding this change consists of two transmittals. The first is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3815CP.pdf> and the second is at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R201NCD.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
August 1, 2017	Initial article released.

MLN Matters® Number: MM10117  
 Related Change Request (CR) Number: 10117  
 Related CR Release Date: July 28, 2017  
 Effective Date: January 18, 2017  
 Related CR Transmittal Number: R201NCD and R3815CP  
 Implementation Date: August 29, 2017, for local MAC system edits; January 2, 2018, for shared system edits

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2016 American Medical Association.*

**Consolidated Billing**

**October update to 2017 codes used for SNF consolidated billing enforcement**

**Provider types affected**

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

**Provider action needed**

Change request (CR) 10163 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing (CB) provision of the SNF prospective payment system (PPS). The CR corrects an error impacting certain claims with dates of service on or after January 1, 2015, that Medicare mistakenly denied/rejected prior to implementation of CR 10163. Make sure your billing staffs are aware of these changes.

**Background**

CR 10163 alerts providers that the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to MACs will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB. The updated lists for institutional and professional billing are available at <https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>.

Certain radiation therapy codes are included as services that are not subject to SNF CB. These codes can be submitted globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC).

When the codes listed below are submitted globally or just for the technical component, the claims are being rejected by Medicare’s common working file (CWF). That is to say, they are not allowed to pay separately outside of the consolidated payment that is made to the SNF.

When submitted with the 26 modifier for just the professional component, the claims have been allowed to pay. The following are the allowable HCPCS codes: 77014, 77750, 77761, 77762, 77763, 77776, 77777, 77778, 77785, 77786, 77787, 77789, 77790, 77799, 79005, 79101, and 79445.

This error is occurring because the codes were not added by CMS to the appropriate coding lists with the 2015, 2016, and 2017 SNF CB annual updates. CR 10163 corrects this error. Therefore, when brought to their attention, your MAC will reprocess claims with dates of service on or after January 1, 2015, that were erroneously denied/rejected.

**Additional information**

The official instruction issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2017Downloads/R3825CP.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/MonitoringPrograms/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

**Document history**

Date of change	Description
August 4, 2017	Initial article released

*MLN Matters*<sup>®</sup> Number: MM10163  
 Related Change Request (CR) Number: 10163  
 Related CR Release Date: August 4, 2017  
 Effective Date: October 1, 2017  
 Related CR Transmittal Number: R3825CP  
 Implementation Date: October 2, 2017

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT<sup>®</sup> only copyright 2016 American Medical Association.*

## Drugs & Biologicals

# October 2017 quarterly ASP Medicare Part B drug pricing files and revisions to prior files

### Provider types affected

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

### What you need to know

Change request (CR) 10187 instructs MACs to download and implement the October 2017 and, if released, the revised July 2017, April 2017, January 2017, and October 2016, ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) data center (CDC). Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 1, 2017, with dates of service October 1, 2017, through December 31, 2017. Make sure your billing staffs are aware of these changes.

### Background

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

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

- File: October 2016 ASP and ASP NOC – Effective dates of service: October 1, 2016, through December 31, 2016

For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3, which is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf>. For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of durable medical equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

### Additional information

The official instruction, CR 10187, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3809cp.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
July 21, 2017	Initial article released

*MLN Matters*<sup>®</sup> Number: MM10187  
 Related CR Release Date: July 21, 2017  
 Related CR Transmittal Number: R3809CP  
 Related Change Request (CR) Number: 10187  
 Effective Date: October 1, 2017  
 Implementation Date: October 2, 2017

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT<sup>®</sup> only copyright 2015 American Medical Association.*

## Durable Medical Equipment

# July quarterly update for 2017 DMEPOS fee schedule

**Note:** This article was revised August 3, 2017, to reflect an updated change request (CR). That CR updated the policy section on complex rehabilitative power wheelchair accessories & seat and back cushions. The CR release date, transmittal number and link to the CR also changed. All other information is the same. This information was previously published in the [May 2017 Medicare B Connection](#), pages 10-11.

### 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.

### Provider action needed

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

Suppliers should continue to use the KU modifier when billing for wheelchair accessories and seat and back cushions furnished in connection with group three complex rehabilitative power wheelchairs (codes K0848 through K0864) with dates of service on or after July 1, 2017. The fee schedule amounts associated with the KU modifier were not adjusted using information from the competitive bidding program in accordance with Section 2 of Patient Access and Medicare Protection Act (PAMPA) for dates of service January 1 through December 31, 2016. Section 16005 of the 21st Century Cures Act then extended the effective date through June 30, 2017. Effective for dates of service on or after July 1, 2017, taking into consideration the exclusion at section 1847(a)(2)(A) of the Social Security Act, the policy for these items is revised. As a result, payment for these items furnished in connection with a group three complex rehabilitative power wheelchair and billed with the KU modifier will be based on the

See **DMEPOS**, next page

## DMEPOS

from previous page

unadjusted fee schedule amounts updated in accordance with Section 1834(a)(14) of the Act. The list of HCPCS codes associated with the KU modifier is available in Transmittal 3713, CR 9966, and dated February 3, 2017. The updated DMEPOS fee schedule files have been released.

### 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 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/R3824CP.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/MonitoringPrograms/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](http://www.cms.gov/Research-Statistics-Data-and-Systems/MonitoringPrograms/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

### Document history

Date of change	Description
August 2, 2017	The article was revised August 3, 2017, to reflect an updated CR. That CR updated the policy section on complex rehabilitative power wheelchair accessories & seat and back cushions. The CR release date, transmittal number and link to the CR were also changed.
May 2, 2017	Initial article released

**MLN Matters®** Number: MM10071 *Revised*  
 Related Change Request (CR) # 10071  
 Related CR Release Date: August 2, 2017  
 Effective Date: July 1, 2017  
 Related CR Transmittal Number: R3824CP  
 Implementation Date: July 3, 2017

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.*

## Laboratory/Pathology

### 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) 10198 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 following approval, the Centers for Medicare & Medicaid Services (CMS) must notify the MACs of the new tests so that they can accurately process claims. CR 10198 lists 17 newly added waived complexity tests.

#### Background

The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid only pay for laboratory tests categorized

as waived complexity under CLIA in facilities with a CLIA certificate or waiver, laboratory claims are currently edited at the CLIA certificate level.

This article includes the latest tests approved by the 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 include:

- 87880QW, December 8, 2016, Quidel Sofia Strep A+ FIA (from throat swab only);
- 80305QW, April 28, 2017, Alere Toxicology Services Alere iCup Rx Multi-Drug Urine Test Cup;
- 82044QW, and 82570QW, May 10, 2017, Acon

See **WAIVED**, next page

**WAIVED**

previous page

Laboratories, Inc. Mission U120 Urine Chemistry Test System (Mission Urinalysis Reagent Strips (Microalbumin/Creatinine));

- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Amphetamine Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Oxazepam Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Cocaine Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Marijuana Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Methamphetamine Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Morphine Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Oxycodone Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Barbiturates Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Buprenorphine Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Methylenedioxymethamphetamine Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Phencyclidine Panel Dip;
- 80305QW, May 16, 2017, Assure Tech. Co., Ltd. AssureTech Methadone Panel Dip;
- 87804QW, May 30, 2017, Quidel Sofia 2 {Sofia Influenza A+B FIA}; and
- 82274QW, G0328QW, June 5, 2017, Jant Pharmacal Coporation Accutest ValuPak Immunochemical Fecal Occult Blood Test.

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

**Additional information**

The official instruction, CR 10198, issued to your



MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3812CP.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
July 28, 2017	Initial article released.

MLN Matters® Number: MM10198  
 Related CR Release Date: July 27, 2017  
 Related CR Transmittal Number: R3812CP  
 Related Change Request (CR) Number: 10198  
 Effective Date: October 1, 2017  
 Implementation Date: October 2, 2017

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2016 American Medical Association.*



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

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

## Preventive Services

# Screening for hepatitis B virus infection

**Note:** This article was revised August 8 to reflect an updated change request (CR) 9859. In the article, the CR release date, transmittal numbers, and the web address of the CR are revised. Also, a clarification was made under “Key points of CR 9859” to denote that HBV is not separately payable for end-stage renal disease (ESRD) TOB 72x unless reported with modifier AY. Another bullet point was added under “Key points of CR 9859” to show that contractor pricing applies to G0499 with dates of service September 28, 2016, through December 31, 2017. All other information is unchanged. This information was previously published in the [July 2017 Medicare A Connection, pages 13-19](#).

### 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

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,  $\geq$  two percent), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection ( $\geq$  eight percent), 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 (HBs Ag) 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.

See **HBV**, next page

## HBV

[previous page](#)

### 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 claims processing instructions for payment of screening for hepatitis B virus will apply to the following HCPCS and CPT® codes:

- HBV screening for asymptomatic, non-pregnant adolescents and adults at high risk - code G0499
- HBV screening for pregnant women - CPT® 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, 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 unless reported with modifier AY.)
- Contractor pricing applies to G0499 with dates of service September 28, 2016, through December 31, 2017.

#### 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 submitted 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,

See **HBV**, next page

## HBV

previous page

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
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 <https://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group code 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 <https://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO

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

See **HBV**, next page

## HBV

previous page

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 <https://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.

- Group code: CO (contractual obligation)

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 at <https://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.

- Group code CO

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 <https://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group code 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 <https://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code - CO (contractual obligation).

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

See **HBV**, next page

## HBV

[previous page](#)

coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <https://www.cms.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

- Group code 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 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/R3831CP.pdf>. The second transmittal updates the *NCD Manual* and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R198NCD.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/](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

### Document history

Date	Description
August 8, 2017	This article was revised to reflect an updated CR 9859. In the article, the CR release date, transmittal numbers, and the web address of the CR are revised. A clarification was made under “Key points of CR 9859” to denote that HBV is not separately payable for ESRD TOB 72x unless reported with modifier AY. Another bullet point was added under “Key points of CR 9859” to show that contractor pricing applies to G0499 with dates of service September 28, 2016, through December 31, 2017. All other information is unchanged.
June 30, 2017	This article was revised to reflect an updated CR 9859. In the article, the CR release date, transmittal numbers, and the web address of the CR are revised. All other information is unchanged.
June 9, 2017	The article was revised to reflect an updated CR that changed the implementation date from January 1, 2018, to January 2, 2018.
May 4, 2017	Initial article released.

MLN Matters® Number: MM9859 *Revised*  
 Related Change Request (CR) #: CR 9859  
 Related CR Release Date: August 4, 2017  
 Effective Date: September 28, 2016  
 Related CR Transmittal #: R3831CP and R198NCD  
 Implementation Date: January 2, 2018

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.*

## Quarterly influenza virus vaccine code update – January 2018

### Provider types affected

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

### Provider action needed

Change request (CR) 10196, from which this article was developed, provides instructions for payment and edits for the common working file (CWF) and the fiscal intermediary shared system (FISS) to include and update new or existing influenza virus vaccine codes. The influenza virus vaccine code set is updated on a quarterly basis. This update will include one new influenza virus vaccine code: 90756. Please make sure your billing staffs are aware of this update.

### Background

Effective for claims processed with dates of service (DOS) on or after January 1, 2018, influenza virus vaccine code 90756 (Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use) will be payable by Medicare. This new code will be included on the 2018 Medicare physician fee schedule database file update and the annual Healthcare Common Procedure Coding System (HCPCS) update.

During the interim period of August 1, 2017, through December 31, 2017, MACs will use code Q2039 (Influenza virus vaccine, not otherwise specified) to handle bills for this new influenza virus vaccine product (Influenza virus vaccine, quadrivalent (cclIV4)). Q2039 is already an active code.

The new influenza virus vaccine code 90756 will then be implemented with the January 2018 release for DOS on or after January 1, 2018.

Effective for dates of service on or after August 1, 2017, MACs will use the CMS seasonal influenza vaccines pricing website 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 Q2039 and 90756.

Medicare will issue further instructions on how to handle claims using Q2039 for the new influenza virus vaccine product between August 1, 2017, and December 31, 2017. MACs will use existing processes to handle these claims.

The new influenza virus vaccine code (90756) is not retroactive to August 1, 2017. Claims will not be accepted for influenza virus vaccine code 90756 between the DOS August 1, 2017, and December 31, 2017. **If claims are received in January 2018, with code 90756 for DOS between August 1, 2017, and December 31, 2017, claims will be rejected or returned as unprocessable.**

### New vaccine description

**Code 90756 – Long description:** Influenza virus vaccine,

quadrivalent (cclIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use TOS code: V

- **Short description:** CCIIV4 VACC ABX FREE IM
- **Medium description:** CCIIV4 VACCINE ANTIBIOTIC FREE 0.5 ML DOS IM USE Long

### Payment basis

Based on reasonable cost, MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:

- Hospitals (types of bill 12x and 13x)
- Skilled nursing facilities (22x and 23x)
- Home health agencies (34x)
- Hospital-based renal dialysis facilities (72x), and
- Critical access hospitals (85x)

Based on the lower of the actual charge or 95 percent of the average wholesale price (AWP), MACs will pay for influenza virus vaccine codes Q2039 and 90756 to:

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

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

MACs will suspend and manually price claims when the HCPC file rate is blank for:

- IHS hospitals (12x, 13x), hospices (81x and 82x), and IHS CAHs (85x)
- CORFs (75x) and
- Independent RDFs (72x)

### Messages for denied claims

MACs will return as unprocessable claims submitted with Q2039 for the DOS January 1, 2018, through July 31, 2018, when code 90756 should have been submitted, using the following messages:

- **Claims adjustment reason code (CARC):** 181 – Procedure code was invalid on the date of service.
- **Remittance advice remark code (RARC):** N56 – Procedure code billed is not correct/valid for the services billed or the date of service billed.
- **Group code:** CO (contractual obligation)

### Additional information

The official instruction, CR 10086, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3827CP.pdf>.

If you have any questions, please contact your MAC at

See **CODE**, next page

Therapy Services

## Updated editing of always therapy services

### Provider type affected

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

### Provider action needed

Change request (CR) 10176 implements revised editing of Part B “always therapy” services to require the appropriate therapy modifier in order for the service to be accurately applied to the therapy cap. CR 10176 contains no new policy. Instead, the guidelines presented in the CR improve the enforcement of longstanding, existing instructions. Make sure your billing staffs are aware of these revisions.

### Background

Services furnished under the outpatient therapy (OPT) services benefit – including speech-language pathology (SLP), occupational therapy (OT), and physical therapy (PT) – are subject to the financial limitations, known as therapy caps, originally required under Section 4541 of the Balanced Budget Act (1997).

There are two such caps. One cap is for PT and SLP services combined and another cap is for OT services. In order to accrue incurred expenses to the correct therapy cap; the use of one of the three therapy modifiers (GN, GO, or GP) is required on a certain set of Healthcare Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under an SLP, OT, or PT plan of care, respectively.

Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy and publishes this list as an annual update on the therapy services billing page at <https://www.cms.gov/Medicare/>

<Billing/TherapyServices/AnnualTherapyUpdate.html>.

On professional claims, each code designated as “always therapy”:

- Must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such,
- Must always be accompanied by one of the GN, GO, or GP therapy modifiers.

In addition, several “always therapy” codes have been identified as discipline-specific – requiring the GN modifier for six codes, the GO modifier for four codes, and the GP modifier for four codes, as illustrated in Tables 1-3.

**Table 1: Codes requiring the “GN” therapy modifier**

Code	CPT® short descriptor	Therapy modifier required
92521	Evaluation of speech fluency	GN
92522	Evaluate speech production	GN
92523	Speech sound lang comprehend	GN
92524	Behavral quality analys voice	GN
92597	Oral speech device eval	GN
92607	Ex for speech device rx 1hr	GN

**Table 2: Codes requiring the “GO” therapy modifier**

Code	CPT® short descriptor	Therapy required modifier
97165	Ot eval low complex 30 min	GO

See **THERAPY**, next page

## CODE

[previous page](#)

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
August 9, 2017	This article was revised to correctly show in all appropriate places the code of Q2039. In the original article, Q0239 was mistakenly referenced in two places and that is corrected to show Q2039. All other information remains the same.

Date of change	Description
August 7, 2017	Article initially released

*MLN Matters*® Number: MM10196  
 Related CR Release Date: August 4, 2017  
 Related CR Transmittal Number: R3827CP  
 Related Change Request (CR) Number: 10196  
 Effective Date: August 1, 2017  
 Implementation Date: January 2, 2018

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.*

# THERAPY

previous page

Code	CPT® short descriptor	Therapy required modifier
97166	Ot eval mod complex 45 min	GO
97167	Ot eval high complex 60 min	GO
97168	Ot re-eval est plan care	GO

**Table 3: Codes requiring the “GP” therapy modifier**

Code	CPT® short descriptor	Therapy required modifier
97161	Pt eval low complex 20 min	GP
97162	Pt eval mod complex 30 min	GP
97163	Pt eval high complex 45 min	GP
97164	Pt re-eval est plan care	GP

The following “always therapy” HCPCS codes require a GN, GO, or GP modifier, as appropriate. Descriptors for these codes are included as an attachment to CR 10176.

92507 92508 92526 92608 92609 96125 97012  
 97016 97018 97022 97024 97026 97028 97032  
 97033 97034 97035 97036 97039 97110 97112  
 97113 97116 97124 97139 97140 97150 97530  
 97532 97533 97535 97537 97542 97750 97755  
 97760 97761 97762 97799 G0281 G0283 G0329

In addition to therapists in private practice (TPPs) – including physical therapists, occupational therapists, and speech-language pathologists – professional claims for OPT services may be furnished by physicians and certain non-physician practitioners (NPPs) – specifically, physician assistants, nurse practitioners, and certified nurse specialists.

All OPT services furnished by TPPs are always considered therapy services, regardless of whether they are designated as “always therapy” or “sometimes therapy.” As such, the appropriate therapy modifier must be included on the claim. However, it may be clinically appropriate for physicians and NPPs to furnish OPT services that have been designated “sometimes therapy” codes outside a therapy plan of care - in these cases, therapy modifiers are not required and claims may be processed without them.

During analyses of Medicare claims data for OPT services, the Centers for Medicare & Medicaid Services (CMS) found that these “always therapy” codes and modifiers are not always used in a correct and consistent manner. CMS found OPT professional claims for “always therapy” codes without the required modifiers. Also, CMS found claims that reported more than one therapy modifier for the same therapy service; for example, both a GP and GO modifier, when only one modifier was allowed.

These claims represent non-compliant billing by TPPs, physicians, and NPPs, and hamper CMS’ ability to properly track the therapy caps and analyze claims data for purposes of Medicare program improvements. The requirements in CR 10176 will create new edits for



Medicare professional claim processing systems to return claims when “always therapy” codes and the associated therapy modifiers are improperly reported.

Providers should expect the following:

- MACs will return/reject claims which contain an “always therapy” procedure code, but do not also contain the appropriate discipline-specific therapy modifier of GN, GO, or GP.
- MACs will also return/reject claims if any service line on the claim contains more than one occurrence of a GN, GO, or GP therapy modifier.
- MACs who are returning/rejecting such claims will use group code CO and claim adjustment reason code (CARC) 4 on the related remittance advice.

## Additional information

The official instruction, CR 10176, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3814CP.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
July 31, 2017	Initial article released.

MLN Matters® Number: MM10176  
 Related CR Release Date: July 27, 2017  
 Related CR Transmittal Number: R3814CP  
 Related Change Request (CR) Number: 10176  
 Effective Date: January 1, 2018  
 Implementation Date: January 2, 2018

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2016 American Medical Association.*

## Surgery

## Percutaneous image-guided lumbar decompression for lumbar spinal stenosis

**Note:** This article was revised July 26, 2017, to reflect the revised CR 10089 issued July 25. In the article, the transmittal numbers, CR release date, implementation date, and the web addresses for accessing the transmittals are revised. All other information remains the same. This information was previously published in the *June 2017 Medicare B Connection*, pages 22-23.

### Provider type affected

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

### Provider action needed

Change request (CR) 10089 announces that effective for dates of service on or after December 7, 2016, Medicare will cover percutaneous image-guided lumbar decompression (PILD) under coverage with evidence development (CED) for beneficiaries with lumbar spinal stenosis (LSS) who are enrolled in a Center for Medicare & Medicaid Services (CMS)-approved prospective longitudinal study. PILD procedures using an FDA-approved/cleared device that completed a CMS-approved prospective, randomized, controlled clinical trial (RCT) that met the criteria are listed in the January 2014 NCD (CR 8757, see related *MLN Matters*<sup>®</sup> article at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8757.pdf>).

### Background

CMS currently covers PILD under the CED paradigm. PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. This is a procedure proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. This procedure is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (for example, fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epidurogram.

Section 1862(a)(1)(E) of the Social Security Act (the Act) authorizes coverage for PILD for beneficiaries with LSS under CED. On January 9, 2014, CMS posted its first NCD (150.13) covering PILD for beneficiaries with LSS when provided in a RCT meeting certain conditions under CED. Clinical studies must be designed using current validated and reliable measurement instruments and clinically appropriate comparator treatments for patients randomized to the non-PILD group.

On April 13, 2016, CMS accepted a complete formal request for a reconsideration of the NCD that limited coverage of PILD for LSS to a CMS-approved prospective RCT. After considering the related published literature and public comments as required by Section 1862(l) of the Act, CMS will expand the January 2014 NCD to cover PILD for LSS under CED through a prospective longitudinal study that meets certain criteria listed in Chapter 1, Section 150.13 of the *NCD Manual* (Pub. 100-03). You should refer to Chapter 1, Section 310 of the *NCD Manual*, as well as Chapter 32, Sections 69 and 330, of the *Medicare Claims Processing Manual* (Pub. 100-04) for more information.

**Note:** As mentioned in MM8954, there are two distinct procedure codes that are to be used: G0276 only for clinical trials that are blinded, randomized, and controlled, and contain a placebo procedure control arm (use CR 8954 for claim processing instructions), and 0275T for **all** other approved clinical trials (use CR 8757 for claim processing instructions).

CR 10089 does not replace but rather is in addition to CR 8757 and CR 8954.

### Additional information

You can review the list of approved clinical studies related to PILD for LSS at <https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html>.

The official instruction, CR 10089, issued to your MAC regarding this change consists of two transmittals. The first modifies the *Medicare Claims Processing Manual* and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3811CP.pdf>. The second updates the NCD manual and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R200NCD.pdf>. The revised sections of both manuals are attached to their respective transmittals.

You may also want to review *MLN Matters*<sup>®</sup> articles MM8401 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf> and MM8954 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8954.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/>.

See PILD, next page

General Coverage

# ICD-10 coding revisions to national coverage determinations

## Provider types affected

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

## Provider action needed

Change request (CR) 10184 outlines edits to International Classification of Diseases, 10th Revision (ICD-10) and other coding updates specific to national coverage determinations (NCDs) that will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. The following link provides the NCD spreadsheets included with this CR 10184 at <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10184.zip>.

## Background

CR 10184 constitutes a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

Previous NCD coding changes appear in ICD-10 quarterly updates that are available at <https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html>, along with other CRs implementing new policy NCDs. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

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

**Note:** The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete general equivalence mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

CR 10084 makes coding and clarifying adjustments to the following NCDs:

- NCD160.18 - Vagus nerve stimulation
- NCD210.4.1 - Counseling to prevent tobacco use
- NCD220.6.17 - Positron emission tomography (PET) for solid tumors
- NCD220.6.20 - PET beta amyloid in dementia/neurological disorders
- NCD210.13 - Screening for hepatitis C virus

**Note/clarification:** MACs will use default Council for Affordable Quality Healthcare Committee on Operating Rules (CAQH CORE) messages where appropriate:

See **NCD**, next page

## PILD

previous page

### Document history

Date of change	Description
June 5, 2017	Initial article released.
July 26, 2017	The article was revised July 26, 2017, to reflect the revised CR 10089 issued July 25. In the article, the transmittal numbers, CR release date, implementation date, and the web addresses for accessing the transmittals are revised. All other information remains the same.

*MLN Matters*® Number: MM10089 *Revised*

Related Change Request (CR) Number: 10089

Related CR Release Date: July 25, 2017

Effective Date: December 7, 2016

Related CR Transmittal Number: R3811CP and R200NCD  
Implementation Date: June 27, 2017

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.*

## NCD

previous page

- Remittance advice remark code (RARC) N386 with claim adjustment reason code (CARC) 50, 96, and/or 119
- See latest CAQH CORE update

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

- Group code PR (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed ABN is on file)
- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file)
- For modifier GZ, use CARC 50 per instructions in CR 7228 at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2148CP.pdf>.

### Additional information

The official instruction issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1875OTN.pdf>.

## New advance beneficiary notice required for use by August 21

The Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to original Medicare (fee-for-service) beneficiaries in situations where Medicare payment is expected to be denied. The Centers for Medicare & Medicaid Services (CMS) has issued a revised ABN that includes an expiration date; there are no additional changes. The

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
August 9, 2017	Initial article released

MLN Matters® Number: MM10184  
 Related CR Release Date: July 27, 2017  
 Related CR Transmittal Number: R1875OTN  
 Related Change Request Number: 10184  
 Effective Date: January 1, 2018  
 Implementation Date: September 13, 2017, for local edits; January 2, 2018, for shared systems

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.*

old forms were acceptable until June 21, 2017, at which time the renewed form became mandatory for use. CMS allowed a 60-day transition period for the renewed forms, thus use of the new form is required as of August 21, 2017.

More information may be found at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>. The new forms may be downloaded at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Forms-English-and-Spanish.zip>.

## Part B billing for certain new biosimilar biological products before the modifier is implemented

Modifiers that identify the manufacturer of a biosimilar biological product are required on Part B claims. CMS updates assignment of modifiers to specific HCPCS codes quarterly. In situations where a HCPCS code is already associated with one or more modifiers and a new biosimilar biological product becomes available before

its corresponding manufacturer's modifier becomes effective, a not otherwise classified (NOC) code without a modifier may be used to bill for the new biosimilar biological product. For more information, visit the Part B biosimilar biological product payment and required modifiers (<https://go.usa.gov/xRQgQ>) webpage.

# NGACO year three benefit enhancements

## Provider types affected

This *MLN Matters*® article is intended for providers who are participating in next generation accountable care organizations (NGACOs) and submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

## Provider action needed

Change request (CR) 10044 provides instruction to MACs to implement two new benefit enhancements for performance year three (2018) of the NGACO model. MACs will process and pay claims for asynchronous telehealth and post-discharge home visit waiver services when those services meet the appropriate payment requirements as outlined in CR 10044. Make sure your billing staff is aware of these changes.

## Background

The aim of the NGACO model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare fee-for-service (FFS) through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, the Centers for Medicare & Medicaid Services (CMS) is issuing the authority under Section 1115A of the Social Security Act (the Act) (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO model.

### Asynchronous telehealth

CMS is expanding the current telehealth waiver to



include asynchronous (also known as “store-and-forward”) telehealth in the specialties of teledermatology and teleophthalmology. Asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients’ condition and adequate for rendering or confirming a diagnosis or treatment plan.

Payment will be permitted for telemedicine when asynchronous telehealth in single or multimedia formats, is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology services. Distant-site practitioners will bill for these new services using new codes, and the distant site practitioner must be an NGACO participant or preferred provider.

See **NGACO**, next page

## ERA

From front page

MACs will not send a SPR/hard copy version to a particular provider/supplier unless this requirement causes hardship and CMS has approved a waiver requested by your MAC.

**Note:** MM4376 is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4376.pdf>.

### Additional information

The official instruction, CR 10151, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1890OTN.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
August 7, 2017	Initial article released.

MLN Matters® Number: MM10151  
 Related CR Release Date: August 4, 2017  
 Related CR Transmittal Number: R1890OTN  
 Related Change Request (CR) Number: 10151  
 Effective Date: January 1, 2018  
 Implementation Date: January 2, 2018

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.*

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

**Note:** This article was revised July 24, 2017, to add links to related MLN Matters® articles. [SE1128](#) reminds all Medicare providers that they may not bill beneficiaries enrolled in the qualified Medicare beneficiary (QMB) program for Medicare cost-sharing. [MM9817](#) states that change request (CR) 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing. All other information remains the same. This information was previously published in the [July 2017 Medicare B Connection](#), pages 13-14.

### Provider type affected

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

### Provider action needed

CR 9911 modifies the Medicare claim processing systems to help providers more readily identify the 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 claims 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.

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. 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 payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a

See **QMB**, next page

## NGACO

previous page

### Asynchronous telehealth based on intra-service + five minutes post-service time

- **Code 1:** G9868– Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, less than 10 minutes.
- **Code 2:** G9869– Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, 10-20 minutes.
- **Code 3:** G9870 – Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the next generation ACO model, 20 or more minutes.

### Additional information

The official instruction, CR 10044, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R177DEMO.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/MonitoringPrograms/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

### Document history

Date of change	Description
August 4, 2017	Initial article released

MLN Matters® Number: MM10044  
 Related Change Request (CR) Number: 10044  
 Related CR Release Date: August 4, 2017  
 Effective Date: January 1, 2018  
 Related CR Transmittal Number: R177DEMO  
 Implementation Date: January 2, 2018

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2016 American Medical Association.*

## QMB

[previous page](#)

Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the *Provider Reimbursement Manual (PRM)*.

CR 9911 aims to support Medicare providers' ability to meet these requirements by modifying the Medicare claims 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 fee-for-service (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 claims 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 claim 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/R3802CP.pdf>.

For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see the *MLN Matters*® 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

Date of change	Description
July 24, 2017	The article was revised to add links to related <i>MLN Matters</i> ® articles. <a href="#">SE1128</a> reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. <a href="#">MM9817</a> states that CR 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing
June 29, 2017	The article was revised to reflect a revised CR 9911 issued June 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. Clarifications were also made to the second paragraph of the <i>Background</i> section.

See **QMB**, next page

## New search capability simplifies LCD lookup

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

Instead of going to an outside website, providers can now locate LCDs faster by searching procedure codes, keywords, or International Classification of Diseases 10th revision codes (ICD-10s) using First Coast's own website search bar.

To find an LCD that corresponds with a specific procedure code, providers may use the site's search bar – located at the top of every page – to search and find an LCD containing that procedure code. Currently, providers use the Medicare Coverage Database (MCD) provided by the Centers for Medicare & Medicaid Services (CMS) in order to find what they are looking for. All of the LCD data is now on the First Coast website, making it simple to find the LCD providers are researching.

Providers can now simply enter a procedure code, keyword, or ICD-10 code into the website search bar and search "LCDs only" to find the matching results. This search function replaces the multiple steps currently

required by other methods, and lets providers locate the corresponding LCDs by using First Coast's own LCD data.

### Multiple ways to locate and view data on the MCD

Options available within the MCD will also help you find LCDs and national coverage determinations (NCDs).

**QUICK SEARCH** – The MCD allows users to search both the NCD and LCD databases using a variety of criteria such as keyword, diagnosis/procedure, and date. Quick search is located at the top right of the [MCD overview page](#).

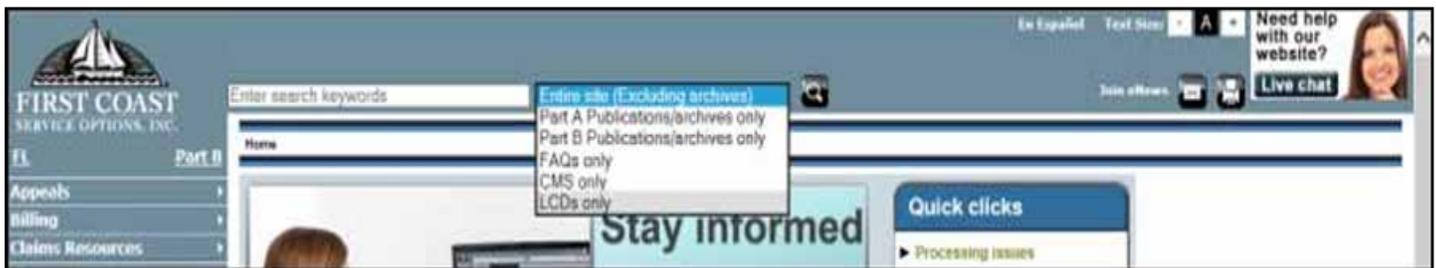
Click **ADVANCED SEARCH** to use additional filters to find exactly what you are looking for.

**INDEXES** – Provides users with pre-defined lists of national and local coverage documents.

**REPORTS** – Provides users with reports of national and local coverage data.

**DOWNLOADS** – Allows users to download complete sets of LCDs and articles and the complete set of NCDs.

For more information about using the MCD, [click here](#).



### QMB

previous page

Date of change	Description
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.
February 3, 2017	Initial article released

MLN Matters® Number: MM9911  
 Related CR Release Date: June 28, 2017  
 Related CR Transmittal Number: R3802CP  
 Related Change Request (CR) Number: CR 9911  
 Effective Date: For claims processed on or after October 2, 2017  
 Implementation Date: October 2, 2017

*Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2016 American Medical Association.*



## Retired LCDs

## Chelation therapy – retired Part B LCD

### LCD ID number: L33809 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the chelation therapy 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

## Intraoperative neurophysiology monitoring – retired Part A and Part B LCD

### LCD ID number: L33379 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the intraoperative neurophysiology monitoring local coverage determination (LCD), it was determined that this LCD and “coding guideline” attachment are no longer required and, therefore, are being retired.

#### Effective date

The retirement of this LCD and “coding guideline” attachment is effective for services rendered **on or after August 11, 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

## Low density lipoprotein (LDL) apheresis – retired Part A and Part B LCD

### LCD ID number: L33381 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the low density lipoprotein (LDL) apheresis 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

rendered **on or after August 11, 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](#).



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](#).

**on or after August 11, 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](#).

## Revisions to LCD

# Label and off-label coverage of outpatient drugs and biologicals – revision to the Part B LCD

**LCD ID number: L33915 (Florida, Puerto Rico/ U.S. Virgin Islands)**

Based on change request (CR) 9386 (*Medicare Benefit Policy Manual*, Pub. 100.02, Chapter 15, Section 50.4.5) the local coverage determination (LCD) for label and off-label coverage of outpatient drugs and biologicals was revised to add Lexi-Drugs to the list of authoritative compendia in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD under “Off Label Use of Drugs”.

### Effective date

This LCD revision is effective for claims processed **on or after February 10, 2016**, for services rendered **on or after August 12, 2015**. 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](#).

## Quarterly provider update

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

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

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

## Upcoming provider outreach and educational events

### Medicare Speaks 2017 Jacksonville

**Date:** Thursday-Friday, September 14-15

**Time:** 7:30 a.m.-4:15 p.m.

**Type of Event:** Face-to-face

[https://medicare.fcso.com/Medicare\\_Speaks/0371641.asp](https://medicare.fcso.com/Medicare_Speaks/0371641.asp)

### Medicare Part B changes and regulations

**Date:** Wednesday, September 20

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

**Type of Event:** Webcast

<https://medicare.fcso.com/Events/0380042.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 *MLN Connects*<sup>®</sup> to its membership as appropriate.

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

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

[View this edition as a PDF](#)

### News & Announcements

- Home Health Agencies: CMS Proposes 2018 and 2019 Payment Changes
- New Medicare Card (formerly called SSNRI)
- Quality Payment Program: Explanation of Special Status Calculation
- Updated CMS Measures Inventory Posted
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis
- Anniversary of the American Disabilities Act

### Provider Compliance

- Hospital Discharge Day Management Services CMS Provider Minute Video

### Claims, Pricers & Codes

- 2018 ICD-10-CM POA Exempt Codes Available

### Upcoming Events

- New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments Listening Session — August 1
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17



- LTCH Quality Reporting Program Refresher Training Webinar — August 22
- CMS National Provider Enrollment Conference — September 6 and 7

### Medicare Learning Network Publications & Multimedia

- Quality Payment Program 2017 MIPS: Improvement Activities Performance Category Web-Based Training Course — New
- Provider/Supplier Enrollment Call: Audio Recording and Transcript — New
- Medicare Part B Immunization Billing Educational Tool — Reminder

The Medicare Learning Network<sup>®</sup>, MLN Connects<sup>®</sup>, and MLN Matters<sup>®</sup> are registered trademarks of the U.S. Department of Health and Human Services (HHS).

## CMS National Provider Enrollment Conference – September 6-7, 2017

North Charleston, South Carolina

**Wednesday, September 6, 2017, from 8 a.m.- 5 p.m. ET**  
**Thursday, September 7, 2017, from 8 a.m.- 4 p.m. ET**

The Centers for Medicare & Medicaid Services (CMS) will hold a National Provider Enrollment Conference

September 6-7, 2017, at the Charleston Area Convention Center in South Carolina. Take advantage of this opportunity to interact directly with CMS and Medicare administrative contractor provider enrollment experts.

Register at <https://www.palmgba.com/events/NPEC2017/> and learn more about this conference.

## MLN Connects® for August 3, 2017

*MLN Connects® for August 3, 2017*

[View this edition as a PDF](#) 

### News & Announcements

- CMS Updates Medicare Payment Rates, Quality Reporting Requirements
- Hospice Benefit: FY 2018 Updates to the Wage Index and Payment Rates
- IRFs: Final FY 2018 Payment and Policy Changes
- SNFs: Final FY 2018 Payment and Policy Changes
- SNF Quality Reporting Program: Reconsideration Period Ends August 13
- Antipsychotic Drug use in Nursing Homes: Trend Update
- Vaccines are Not Just for Kids

### Provider Compliance

- Reporting Changes in Ownership

### Claims, Pricers & Codes

- ICD-10 GEMS for 2018 Available

### Upcoming Events

- SNF Quality Reporting Program: Review and Correct Reports Refresher

- Training Webinar — August 7
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
- CMS National Provider Enrollment Conference — September 6 and 7
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7
- Comparative Billing Report on IPPE/AWV Webinar — September 13

### Medicare Learning Network Publications & Multimedia

- Medicare Part B Immunization Billing Educational Tool — Revised
- The ABCs of the Annual Wellness Visit Educational Tool — Reminder

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

## MLN Connects® for August 10, 2017

*MLN Connects® for August 10, 2017*

[View this edition as a PDF](#) 

### News & Announcements

- Medicare Card: Webpage Updates
- IRF Quality Reporting Program: Reconsideration Period Ends August 17
- LTCH Quality Reporting Program: Reconsideration Period Ends August 17
- Hospice Quality Reporting Program: Reconsideration Period Ends August 17
- EHR Incentive Program Hardship Exception Application Due by October 1
- Hospitals: Submit Meaningful Use Data to the HQR via the QualityNet Secure Portal in 2018
- Chronic Care Management: New Connected Care Videos
- Medicare Fee-For-Service Beneficiary Selection of a Primary Clinician
- Home Health Quality Reporting Program: OASIS-C2 2018 Guidance Manual Available
- Quality Payment Program Hardship Exception Application for 2017 Transition Year Open
- Quality Payment Program: Explanation of Special Status Calculation — Correction



### Provider Compliance

- Home Health Care: Proper Certification Required

### Claims, Pricers & Codes

- July 2017 OPPS Pricer File
- Part B Billing for Certain New Biosimilar Biological Products before the Modifier is Implemented

### Upcoming Events

- IRF Quality Reporting Program Refresher Training Webinar – August 15
- Medicare Diabetes Prevention Program Model Expansion Listening Session – August 16

See **MLN CONNECTS®**, next page

# MLN Connects® for August 17, 2017

MLN Connects® for August 17, 2017

View this edition as a PDF 

## News & Announcements

- CMS Releases Hospice Compare Website to Improve Consumer Experiences, Empower Patients
- Proposed Changes to Comprehensive Care for Joint Replacement Model, Cancellation of Other Models
- CMS Releases Updated Data on Medicare Hospice Utilization and Payment
- SNF Quality Reporting Program Web-based Training Module Available
- Beneficiary Notices: Large Print Forms Available

## Provider Compliance

- Inpatient Skilled Nursing Facility Denials

## Claims, Pricers & Codes

- 2018 ICD-10-CM Coding Guidelines and Conversion Table Available

## Upcoming Events

- IMPACT Act: Medicare Spending Per Beneficiary Measures Call – September 6
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call – September 7



## Medicare Learning Network Publications & Multimedia

- Care Management Listening Session: Audio Recording and Transcript – New
- Medicare Parts A & B Appeals Process Booklet – Revised
- DMEPOS Information for Pharmacies Fact Sheet – Revised
- DMEPOS Accreditation Fact Sheet – Revised

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

## MLN Connects®

from previous page

- Quality Payment Program Year 2 NPRM Virtual Office Hours Session – August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call – August 17
- LTCH Quality Reporting Program Refresher Training Webinar – August 22
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call – September 7

## Medicare Learning Network Publications & Multimedia

- August 2017 Catalog Available

- Quality Payment Program 2017: MIPS Quality Performance Category Web-Based Training Course – New
- Long-Term Care Call: Audio Recording and Transcript– New
- ESRD Listening Session: Audio Recording and Transcript – New
- Medicare Secondary Payer Web-Based Training Course – Revised
- Medicare Secondary Payer Booklet – Revised

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

## 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@fcsso.com](mailto:FloridaB@fcsso.com)  
Online form: <https://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@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  
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  
<https://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: <https://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

### Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor

<https://medicare.fcsso.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

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: <https://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 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

FOIA Puerto Rico  
P.O. Box 45092  
Jacksonville, FL 32232-5092,

### 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  
<https://medicare.fcsso.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>

## Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to First Coast Service Options Inc. account # (use appropriate account number). Do not fax your order; it must be mailed.

**Note:** Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
<p><b>Part B subscription</b> – The Medicare Part B jurisdiction N publications, in both Spanish and English, are available free of charge online at <a href="https://medicare.fcso.com/Publications_B/index.asp">https://medicare.fcso.com/Publications_B/index.asp</a> (English) or <a href="https://medicareespanol.fcso.com/Publicaciones/">https://medicareespanol.fcso.com/Publicaciones/</a> (Español). Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2016 through September 2017.</p>	40300260	\$33		
<p><b>2017 fee schedule</b> – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2017, are available free of charge online at <a href="https://medicare.fcso.com/Data_files/">https://medicare.fcso.com/Data_files/</a> (English) or <a href="https://medicareespanol.fcso.com/Fichero_de_datos/">https://medicareespanol.fcso.com/Fichero_de_datos/</a> (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items.</p> <p><b>Note:</b> Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.</p>	40300270	\$12		
Language preference: <b>English</b> [ ] <b>Español</b> [ ]				
<i>Please write legibly</i>			Subtotal	\$
			Tax ( <b>add % for your area</b> )	\$
			Total	\$

**Mail this form with payment to:**  
**First Coast Service Options Inc.**  
**Medicare Publications**  
**P.O. Box 406443**  
**Atlanta, GA 30384-6443**

Contact Name: \_\_\_\_\_

Provider/Office Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

*(Checks made to "purchase orders" not accepted; all orders must be prepaid)*