

C Medicare B ONNECTION

medicare.fcso.com



A Newsletter for MAC Jurisdiction N Providers

October 2016



In this issue

Ambulance inflation factor for 2017	5
January update to the laboratory NCD edit software....	9
Implementation of new influenza virus vaccine code .	12
Amount in controversy updates for 2017	14
2017 ICD-10-CM coding changes to LCDs	18
New CERT documentation contractor	27

CMS finalizes the new Medicare quality payment program

On October 14, HHS finalized its policy implementing the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) incentive payment provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), collectively referred to as the Quality Payment Program. The new Quality Payment Program will gradually transform Medicare payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care system.

The final rule with comment period offers a fresh start for Medicare by centering payments around the care that is best for the patients, providing more options to clinicians for innovative care and payment approaches, and reducing administrative burden to give clinicians more time to spend with their patients, instead of on paperwork.

Accompanying the announcement is a new [Quality Payment Program](#) website, which will explain the new program and help clinicians easily identify the measures most meaningful to their practice or specialty.

For More Information:

- [Final Rule](#) and [Executive Summary](#)



- [Press Release](#)
- [Fact Sheet](#)
- [Quality Payment Program](#)

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



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

About the Medicare B Connection

About the 'Medicare B Connection'	3
Advance beneficiary notices	4

Coverage/Reimbursement

Ambulance

Ambulance inflation factor for 2017 and productivity adjustment.....	5
Widespread probe notification for HCPCS codes A0427 and A0428.....	5

Clinical Trials

Allogeneic hematopoietic stem cell transplantation.....	6
---	---

Drugs & Biologicals

ASP reporting by manufacturers – blending national drug codes	8
January update to the laboratory NCD edit software	9

Laboratory/Pathology

FFS data collection system: CLFS data reporting template.....	10
---	----

Preventive Services

Hepatitis B deductible and coinsurance and HPV processing.....	11
Implementation of new influenza virus vaccine code.....	12

General Information

Internet-only manual updates to correct errors and omissions	13
Fingerprint-based background check began August 6, 2014.....	14
Amount in controversy updates for 2017....	14

Processing Issues

Reprocessing of HCPCS code G0472	14
--	----

Local Coverage Determinations

Looking for LCDs?.....	15
Advance beneficiary notice.....	15

Retired LCDs

Renal angiography	16
-------------------------	----

Revisions to LCDs

Amniotic membrane sutureless placement on the ocular surface	16
Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications.....	16
Noncovered services.....	17
Transthoracic echocardiography (TTE).....	17
Screening and diagnostic mammography ..	17

Additional Information

2017 ICD-10-CM coding changes	18
New CERT documentation contractor effective October 14, 2016	27

Educational Resources

Upcoming provider outreach and educational event	32
--	----

CMS MLN Connects™ Provider eNews

eNews for September 29, 2016.....	33
eNews for October 6, 2016.....	34
eNews for October 13, 2016.....	35
eNews for October 20, 2016.....	35

Contact Information

Florida Contact Information	36
U.S. Virgin Islands Contact Information	37
Puerto Rico Contact Information	38

Order Form

Medicare Part B materials	39
---------------------------------	----

Appendix A

Clinical Laboratory Fee Schedule Data Reporting Template - Quick User Guide

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:

Liliana Chaves-Merchan
Terri Drury
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 2014 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 2015 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.



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.*

About the 'Medicare B Connection'

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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



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

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

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

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

Never miss an appeals deadline again

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

Medicare Part B advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

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



ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

Ambulance

Ambulance inflation factor for 2017 and productivity adjustment

Provider types affected

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

Provider action needed

Change request (CR) 9811 furnishes the 2017 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. Make sure that your billing staffs are aware of the change.

Background

CR 9811 furnishes the 2017 ambulance inflation factor (AIF) for determining the payment limit for ambulance services required by Section 1834(l)(3)(B) of the Social Security Act (the Act).

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

Section 3401 of the Affordable Care Act requires that specific prospective payment system (PPS) and fee schedule (FS) update factors be adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as

projected by the Secretary of Health and Human Services (the Secretary) for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period).

The MFP for 2017 is 0.3 percent and the CPI-U for 2017 is 1.0 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for 2017 is 0.7 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Additional information

The official instruction, CR 9811, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3625CP.pdf>.

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

MLN Matters[®] Number: MM9811

Related Change Request (CR) #: CR 9811

Related CR Release Date: October 14, 2016

Effective Date: January 1, 2017

Related CR Transmittal #: R3625CP

Implementation Date: January 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.

Widespread probe notification for HCPCS codes A0427 and A0428

First Coast Service Options Inc. (First Coast) will conduct a widespread probe (WSP) in response to an aberrant billing pattern identified for Healthcare Common Procedure Coding System (HCPCS) codes A0427 (Ambulance service, advanced life support, emergency transport, level I) and A0428 (Ambulance service, basic life support, non-emergency transport).

Provider type affected specialty 59 Ambulance Company. CERT reviews indicated the errors were based on

insufficient documentation to support the services billed that include missing signature, signed physician certification for the ambulance transport, and clinical documentation to support medical necessity for billed ambulance services.

First Coast will complete a WSP for dates of service February 1, 2016, to July 31, 2016, to validate the documentation supports the medical necessity and the level of ambulance service billed.

Clinical Trials

Allogeneic hematopoietic stem cell transplantation

Note: This article was revised September 26, 2016, to correct the language regarding the submission of professional claims in the “Background” section of the article. All other information remains the same. This information was previously published in the July 2016 Medicare B Connection, pages 7-9.

Provider types affected

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

Provider action needed

CR 9620, from which this article was developed, notifies providers that effective for claims with dates of service on and after January 27, 2016, for the use of allogeneic hematopoietic stem cell transplantation (HSCT) for treatment of multiple myeloma, myelofibrosis, and sickle cell disease is covered by Medicare, but only if provided in the context of a Medicare-approved clinical study meeting specific criteria under the coverage with evidence development (CED) paradigm.

CR 9620 also clarifies the ICD-9 and ICD-10 diagnosis codes for allogeneic HSCT for treatment of myelodysplastic syndromes (MDS) in the context of a Medicare-approved, prospective clinical study under CED. Specifically, for dates of service on or after August 4, 2010, through September 30, 2015, the ICD-9-CM diagnosis codes are 238.72, 238.73, 238.74, or 238.75 **and** clinical trial ICD-9-CM diagnosis code V70.7. For dates of service on or after October 1, 2015, the ICD-10-CM diagnosis codes are D46.A, D46.B, D46.C, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, or D46.Z **and** clinical trial ICD-10-CM diagnosis code Z00.6. Make sure your billing staff is aware of these determinations.

Background

HSCT is a process that includes mobilization, harvesting, and transplant of stem cells and the administration of high-dose chemotherapy and/or radiotherapy prior to the actual transplant. During the process stem cells are harvested from either the patient (autologous) or a donor (allogeneic) and subsequently administered by intravenous infusion to the patient.

Multiple myeloma is a neoplastic plasma-cell disorder. Myelofibrosis is a stem cell-derived hematologic disorder. Sickle cell disease is a group of inherited red blood cell disorders created by the presence of abnormal hemoglobin genes. On April 30, 2015, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request from the American Society for Blood and Marrow Transplantation (ASBMT) to reconsider its policy and expand coverage of allogeneic HSCT for sickle cell disease, myelofibrosis, multiple myeloma, and rare diseases.

Myelodysplastic syndrome (MDS) refers to a group of

diverse blood disorders in which the bone marrow does not produce enough healthy, functioning blood cells. On August 4, 2010, CMS issued a final decision stating that allogeneic HSCT for MDS is covered by Medicare only if provided pursuant to a Medicare-approved clinical study under CED. CR 7137 (see the article, MM7137 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7137.pdf>) provides specific ICD-9 related coding and claim processing requirements regarding this particular coverage decision, and CRs 8197 and 8691 (see MM8197 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8197.pdf> and MM8691 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.pdf>) provide ICD-10 related coding requirements. On November 30, 2015, CMS accepted a formal request from the national marrow donor program (NMDP) to clarify the list of ICD-9-CM and ICD-10-CM diagnosis codes covered for allogeneic HSCT for the treatment of MDS in the context of a Medicare-approved clinical study under CED.

On January 27, 2016, CMS issued a final decision to expand national coverage of items and services necessary for research in an approved clinical study via coverage with evidence development (CED) under Section 1862(a)(1)(E) of the Social Security Act (the Act) for allogeneic HSCT for the following indications:

- Multiple myeloma
- Myelofibrosis
- Sickle cell disease

Refer to the following Medicare manual sections for more information regarding this NCD and further billing instructions specific to this NCD and the business requirements specific to CR 9620:

- Chapter 1, Section 110.23, of the *Medicare NCD Manual*, which is attached to the CR 9620 NCD transmittal at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R191NCD.pdf>.
- Chapter 1, Section 310.1, of the *Medicare NCD Manual*, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf, and
- Chapter 32, Sections 69 and 90, of the *Medicare Claims Processing Manual*, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf>.

Please note, Chapter 1, Section 110.8.1 has been removed from the NCD Manual and incorporated into Chapter 1, Section 110.23.

In addition to the diagnosis codes detailed at the beginning of this article, providers need to be aware of the other

See HSCT, next page

HSCT

previous page

billing requirements, as follows:

Inpatient claims

For claims submitted on type of bill 11x for discharges on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- ICD-10-PCS procedure code of 30230G1, 30230Y1, 30233G1, 30233Y1, 30240G1, 30240Y1, 30243G1, 30243Y1, 30250G1, 30250Y1, 30253G1, 30253Y1, 30260G1, 30260Y1, 30263G1, **or** 30263Y1 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**
- Condition code 30, denoting qualifying clinical trial **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
 - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
 - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Outpatient claims

For claims submitted on type of bill 13x or 85x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**
- Condition code 30, denoting qualifying clinical trial **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
 - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
 - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Method II critical access hospital (CAH) claims

For claims submitted on type of bill 85x with revenue codes 96x, 97x, or 98x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**

- Condition code 30, denoting qualifying clinical trial **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
 - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
 - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Professional claims

For professional claims submitted for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240 **and**
- The clinical trial ICD-10-CM code of Z00.6 **and**
- The Q0 modifier **and**
- A place of service code of 19, 21, or 22 along with the appropriate ICD-10-CM diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 **or**
 - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 **or**
 - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

For all of the above claims types submitted without the requisite coding, MACs will deny the claims using the following messages:

- **Claim adjustment reason code (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.
- **Remittance advice remarks code (RARC) N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.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** - Patient responsibility (PR) if an advance beneficiary notice (ABN)/hospital notice on non-coverage (HINN), otherwise contractual obligation (CO)

For claims with dates of service prior to the implementation date of CR 9620, MACs shall perform necessary adjustments only when the provider brings such claims to the attention of their MAC.

See **HSCT**, next page

HSCT

[previous page](#)

Additional information

The official instruction, CR 9620, consists of two transmittals. The first updates the *Medicare Claims Processing Manual* at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3556CP.pdf>. The second transmittal updates the *Medicare NCD Manual* at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R193NCD.pdf>.

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

Document history

Date of change	Description
September 26, 2016	The article was revised to correct the language on page 4 regarding professional claims.

Date of change	Description
July 5, 2016	The article was revised due to an updated change request (CR). That CR revised shared system maintainer (SSM) responsibility. The transmittal number, CR release date and link to the transmittal also changed.
May 9, 2016	Initial article release

MLN Matters® Number: MM9620 [Revised](#)
 Related Change Request (CR) #: CR 9620
 Related CR Release Date: July 1, 2016
 Effective Date: January 27, 2016
 Related CR Transmittal #: R193NCD and R3556CP
 Implementation Date: October 3, 2016

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.

Drugs & Biologicals

Medicare Part B drug ASP reporting by manufacturers – blending national drug codes

Provider types affected

This article is intended for drug manufacturers who submit average sales price (ASP) data to the Centers for Medicare & Medicaid Services (CMS).

Background

Payment for many Medicare Part B drugs is based on ASP drug pricing data submitted to CMS by drug manufacturers. In accordance with Section 1847A of the Social Security Act (the Act), manufacturers must submit ASP data, including total sales and volume for their products, 30 days after the current calendar quarter closes.

What you need to know

CMS is reminding manufacturers that ASP data must be reported for individual national drug codes (NDCs). As stated on page 45 of *ASP Data Collection (Addendum A) User's Guide – Revised 2012* in the *Downloads* section at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html>, “most ASP reporting is done at the NDC level where the ASP corresponds to the amount of drug represented by that NDC.... For these drugs and biologicals, manufacturers will still submit ASP sales data for an NDC, but will do so on an ASP unit level specified in this list.” Manufacturers should not blend the manufacturer’s ASP or the number of ASP Units sold for a single NDC with other NDCs.

CMS also reminds manufacturers that misreporting of ASP sales data may result in civil monetary penalties as described in Section 1847A(d)(4) of the Act.

Exceptions to ASP reporting by NDC are limited and are available in the document titled “ASP Report in Units other Than NDC – January 2016” in the Related Links section at <https://www.cms.gov/McrPartBDrugAvgSalesPrice/>.

Additional information

If you have questions about the information in this reminder, please email them to the ASP mailbox at sec303aspdata@cms.hhs.gov.

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

MLN Matters® Number: SE1623
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A

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

January update to the laboratory NCD edit software

Provider types affected

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

Provider action needed

Change request (CR) 9806 announces changes that will be included in the January 2017 quarterly release of the edit module for clinical diagnosis laboratory services. Make sure your billing staffs are aware of these changes to ensure proper billing to Medicare.

Background

The national coverage determination (NCD) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published November 23, 2001. Medicare developed nationally uniform software that was incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12-190.34) were processed uniformly throughout the United States effective April 1, 2003.

CR 9806 communicates requirements to Medicare system maintainers and the MACs regarding changes to the NCD code lists used for laboratory claim edit software for January 2017. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-10-CM codes. Please see Section II (business requirements table) of CR 9806 for the lengthy list of codes added or deleted. Note that where codes are deleted, the effective date of deletion is September 30, 2016, and the effective date for codes added is October 1, 2016.



Additional information

The official instruction, CR 9806, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3614CP.pdf>.

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

MLN Matters[®] Number: MM9806

Related Change Request (CR) #: CR 9806

Related CR Release Date: September 23, 2016

Effective Date: October 1, 2016

Related CR Transmittal #: R3614CP

Implementation Date: January 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.



Learn the secrets to billing Medicare correctly

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

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

Fee-for-service data collection system: Clinical laboratory fee schedule data reporting template

Editor's note: The corresponding quick user guide referenced under "What you need to know" has been added as an appendix and may be found after page 40. This information was previously published in the [September 2016 Medicare B Connection](#), page 14. The article omitted the "Document History" section and therefore, is being republished to include the omitted section.

Provider types affected

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

What you need to know

This guidance is intended to assist the laboratory community in meeting the new requirements under Section 1834A of the Social Security Act (the Act) for the Medicare Part B clinical laboratory fee schedule (CLFS). The quick user guide that includes guidance for the fee-for-service data collection system (FFSDCS) CLFS data reporting template, is included as an attachment to this article (Appendix A).

Note: The FFSDCS is undergoing its final stage of testing and will not be accessible to the public until November 2016. Laboratories can view the required format for reporting their data through the FFSDCS on the clinical laboratory fee schedule web page.

Additional information

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

If you have questions about requirements for the new CLFS, please email them to the CLFS Inquiries mailbox at CLFS_Inquiries@cms.hhs.gov.

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



Document history

Date of change	Description
September 14, 2016	The article was revised to update the attached manual. The illustrations for the notepad and excel were changed. In the table on page 3 the field name "test name" was removed.
September 8, 2016	Initial article release

MLN Matters® Number: SE1620
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation N/A

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.

Your Feedback Matters

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

Preventive Services

Update to hepatitis B deductible and coinsurance and screening Pap smear claim processing

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.

What you need to know

Change request (CR) 9778 informs MACs about the updates to language regarding coinsurance and deductible for hepatitis B in the Chapter 18, Section 10 of the *Medicare Claims Processing Manual* to show that coinsurance and deductible for hepatitis B virus vaccine are waived. This is not a change in current policy and the CR only updates the manual to show current policy. CR 9778 also removes subsection D from Sections 30.8 and 30.9 of Chapter 18 of the manual, which contained incorrect claims processing instructions regarding processing claims with HCPCS code G0476, HPV screening, when submitted on a type of bill other than 12x, 13x, 14x, 22x, 23x, and 85x.

Additional information

The official instruction, CR 9778, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3615CP.pdf>.

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



MLN Matters® Number: MM9778
Related Change Request (CR) #: CR 9778
Related CR Release Date: September 23, 2016
Effective Date: December 27, 2016
Related CR Transmittal #: R3615CP
Implementation Date: December 27, 2016

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.

Medicare Learning Network®

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

Implementation of new influenza virus vaccine code

Provider types affected

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

Provider action needed

Change request (CR) 9793 which informs MACs about the changes to instructions for payment and edits for the common working file (CWF) to include influenza virus vaccine code 90674 (Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use) as payable for claims with dates of service on or after August 1, 2016, processed on or after January 3, 2017. Make sure that your billing staffs are aware of these changes.

Background

CR 9793 provides instructions for payment and edits to include influenza virus vaccine code 90674. Medicare waives coinsurance and deductibles for code 90674. Medicare will pay for code 90674 based on reasonable costs when submitted by:

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

MACs will pay for influenza virus vaccine code 90674 based on the lower of the actual charge or 95 percent of the average wholesale price (AWP) to:

- Indian health services (IHS) hospitals submitting claims on TOB 12x and 13x
- IHS CAHs submitting claims on TOB 85x
- Comprehensive outpatient rehabilitation facilities using TOB 75x, and
- Independent renal dialysis facilities using TOB 72x

It is important to note that MACs will hold institutional claims with code 90674 with dates of service on or after January 1, 2017, through February 20, 2017, until the fiscal intermediary shared system (FISS) changes are implemented February 20, 2017.

Medicare will issue further instructions on how to handle claims for **code 90674 with dates of service from**

August 1, 2016, through December 31, 2016.

Medicare will use the Centers for Medicare & Medicaid Services (CMS) seasonal influenza vaccines pricing web page 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 90674. This applies to professional claims with dates of service on or after August 1, 2016.

Coinsurance and deductible do not apply.

Additional information

The official instruction, CR 9793, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3617CP.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
October 21, 2016	The article was revised to correct a date on page 2 (<i>Background</i> section) in bold. The dates should have read, "... from August 1, 2016, through December 31, 2016.
September 30, 2016	Initial article post

MLN Matters[®] Number: MM9793

Related Change Request (CR) #: CR 9793

Related CR Release Date: September 30, 2016

Effective Date: August 1, 2016

Related CR Transmittal #: R3617CP

Implementation Date: January 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.

General Information

Internet-only manual updates to correct errors and omissions

Note: This article was revised on October 17, 2016, to reflect a new change request (CR). That CR revised Chapter 8 to correct minor omissions in Sections 10.2 and 70. Additionally, Section 20 was removed from the CR in order to rescind unclear wording (bold under “Key points of CR 9748”). The transmittal number, CR release date and link to the transmittal were also changed. All other information remains the same. This information was previously published in the [September 2016 Medicare B Connection, page 24](#).

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) 9748 revises the following Medicare manuals to correct various minor technical errors and omissions:

- Medicare General Information, Eligibility, and Entitlement Manual
- Medicare Benefit Policy Manual
- Medicare Claims Processing Manual

The revisions of these manuals are intended to clarify the existing content, and no policy, processing, or system changes are anticipated.

Key points of CR 9748

CR 9748 includes all revisions as attachments, and selected extracts from these attachments are as follows:

‘Medicare General Information, Eligibility, and Entitlement Manual’ revision summary

- Chapters 4 and 5 of this manual are revised to include references to another manual with related information and a reference to a related regulation.

‘Medicare Benefit Policy Manual’ summary of key revisions

- In several sections, references to related material in other manuals are included.
- Language is added to refer providers to a list of exclusions from consolidated billing (CB, the SNF “bundling” requirement), which is available at <https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>.
- Language that was initially added by CR 9748 in Transmittal R227BP to §20 of Chapter 8, regarding the scope and purpose of Medicare’s post-hospital extended care benefit, inadvertently included unclear wording and has been rescinded

by Transmittal R228BP. As a result, the original version of this section’s text, as it read prior to that revision, is now restored.

‘Medicare Claims Processing Manual’ key revision summary

- In several sections, references to related material in other manuals are included.

Additional information

The official instruction, CR 9748, issued to your MAC regarding this change is available via three transmittals:

- The first updates the *Medicare General Information, Eligibility, and Entitlement Manual* at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R101GI.pdf>.
- The second transmittal updates the *Medicare Benefit Policy Manual* is at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R228BP.pdf>.
- The thirds updates the *Medicare Claims Processing Manual* at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3612CP.pdf>.

Document history

Date of change	Description
October 17, 2016	The article was revised October 17, 2016, to reflect a new CR. That CR revised Chapter 8 to correct minor omissions in Sections 10.2 and 70. Additionally, Section 20 was removed from the CR in order to rescind unclear wording. The transmittal number, CR release date and link to the transmittal were also changed.
September 18, 2016	Initial article post

MLN Matters® Number: MM9748
 Related Change Request (CR) #: CR 9748
 Related CR Release Date: October 13, 2016
 Effective Date: October 18, 2016
 Related CR Transmittal #: R101GI, R228BP, and R3612CP
 Implementation Date: October 18, 2016

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.

Fingerprint-based background check began August 6, 2014

Note: This article was rescinded October 17, 2016. For information on the fingerprint-based background check requirement, view *MLN Matters*® article SE1417, “Implementation of Fingerprint-Based Background Checks”, available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf>. This information was previously published in the *September 2014 Medicare B Connection*, page 33.

MLN Matters® Number: SE1427 *Rescinded*
 Related Change Request (CR) #: N/A

Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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.

Amount in controversy updates for 2017

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides for annual reevaluation of the dollar amount in controversy (AIC) required for an administrative law judge (ALJ) hearing (third level review) and federal district court review (fifth level review).

For requests made on or after January 1, 2017:

- The amount that must remain in controversy for ALJ hearing requests is increased to \$160.
- The amount that must remain in controversy for federal district court review is increased to \$1,560.

Processing Issues

Reprocessing of HCPCS code G0472

Issue

Healthcare Common Procedure Coding System (HCPCS) code G0472 (Hepatitis C antibody screening, for individuals at high risk and other covered indications) was denied in error from January 5, 2015, through May 31, 2016, for beneficiaries born between 1945-1965.

Resolution

Medicare administrative contractors (MACs) have updated their systems to correct this problem

and will reprocess denied claims.



Status/date resolved

Closed. The system was corrected June 1, 2016; mass adjustments to reprocess affected claims were completed September 15, 2016

Provider action

None.

Current processing issues

Here is a link to a [table of current processing issues](#) for both Part A and Part B.

Where do I find...

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



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

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

Effective and notice dates

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

Electronic notification

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

More information

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

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



Looking for LCDs?

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

Advance beneficiary notice

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

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

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

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

Before you file an appeal...

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

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



Retired LCD

Renal angiography – Part AB LCD retired

LCD ID number: L33715 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for renal angiography is being retired as the limited indications for renal angiography have been incorporated into the new LCD aortography and peripheral angiography (L36767). The new LCD addresses the indications and limitations of coverage and/or medical necessity, CPT® codes, ICD-10-CM diagnosis codes, documentation guidelines, and utilization guidelines for invasive diagnostic arteriography procedures performed for the purpose of evaluating vascular disease. Therefore, the LCD for renal angiography is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after October 31, 2016**. First Coast

Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://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 LCDs

Amniotic membrane sutureless placement on the ocular surface – revision to the Part AB LCD

LCD ID number: L36237 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for amniotic membrane-sutureless placement on the ocular surface was revised under the “Limitations” section of the LCD to clarify amniotic membrane for sutureless application of the eye must be cleared by, or registered with, the U.S. Food and Drug Administration (FDA).

Effective date

This LCD revision is effective for services rendered **on or after October 13, 2016**. First Coast Service Options Inc.

LCDs are available through the CMS Medicare coverage database at <http://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](#).



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

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

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was revised to replace ICD-10-CM diagnosis codes M89.9 and M94.9 with ICD-10-CM diagnosis code range M85.80-M85.9 in the “ICD-10 Codes that Support Medical Necessity” section of the LCD for HCPCS code J0897 (Prolia®).

Effective date

This LCD revision is effective for services rendered **on or after October 14, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://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](#).

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

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

The local coverage determination (LCD) for noncovered services was revised to remove Current Procedural Terminology (CPT®)/HCPCS codes 52441, 52442, C9739, C9740, and L8699 (Prosthetic implant, not otherwise specified [when used for the transprostatic urethral lift implant]) under the “CPT®/HCPCS Codes” sections of the LCD, due to the development of a new LCD (prostatic urethral lift [PUL] - L36775). The new LCD-Prostatic Urethral Lift (PUL) is currently in the 45-day notice period and will become effective 10/31/2016.

Effective date

The LCD revision to remove CPT®/HCPCS codes 52441, 52442, C9739, C9740, and L8699 is effective for services rendered **on or after October 31, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://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](#).

Transthoracic echocardiography (TTE) – revision to the Part AB LCD

LCD ID number: L33768 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request to include a diagnosis code when transthoracic echocardiography (TTE) is performed to monitor cardiac toxicity of chemotherapeutic agents during therapy, the local coverage determination (LCD) for transthoracic echocardiography was revised to add ICD-10-CM diagnosis code Z01.89 (Encounter for other specified special examinations) to the “ICD-10 Codes that Support Medical Necessity” section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after October 20, 2016**, for services rendered **on or after October 01, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://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](#).

Screening and diagnostic mammography – revision to the Part A and Part B LCD

LCD ID number: L36342 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 9631 (Coding Revisions to National Coverage Determinations), the local coverage determination (LCD) for screening and diagnostic mammography was revised to remove unspecified ICD-10-CM diagnosis codes C50.019, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.919, C50.929, C56.9, C78.00, C79.60, D05.00, D05.10, D05.80, D05.90, D24.9, D48.60, N60.09, N60.19, N60.29, N60.39, N60.49, N60.89, N60.99, S20.00XA, S21.009A, S21.019A, S21.029A, S21.039A, S21.049A, S21.059A, S28.219A, and S28.229A from the “ICD-10 Codes that Support Medical Necessity” section of the LCD for *Current Procedural Terminology* (CPT®)/HCPCS codes 77055, 77056, G0204, G0206, and G0279.

In addition, based on CR 9677 (Annual Update of the International Classification of Diseases), ICD-10-CM diagnosis code N61 has been deleted from the “ICD-10 Codes that Support Medical Necessity” section of the LCD for CPT®/HCPCS codes 77055, 77056, G0204, G0206, and G0279.

Effective date

This LCD revision is effective for services rendered **on or after October 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at <http://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](#).

Additional Information

2017 ICD-10-CM coding changes

The 2017 update to the ICD-10-CM diagnosis coding structure is effective for services rendered on or after October 1, 2016. Contractors will no longer be able to accept discontinued diagnosis codes for dates of service after the date on which the diagnosis code is discontinued. The First Coast Service Options Inc. (First Coast) medical policy team has evaluated all active local coverage determinations (LCDs) for diagnosis criteria that are impacted by the 2017 ICD-10-CM update. As a reminder, diagnosis codes included in an LCD are surrogate to the indications addressed within the LCD and providers are required to bill the highest level of specificity for the applicable diagnosis code when reporting services.

The following table lists the LCDs affected and the specific conditions revised as a result of the 2017 ICD-10-CM update:

LCD database ID number	LCD title	2017 changes
L33256	3D Interpretation and Reporting of Imaging Services	Removed diagnosis code R93.4 for procedure codes 76376 and 76377. Added diagnosis codes R93.41, R93.421, R93.422, and R93.49 for procedure codes 76376 and 76377.
L33268	Bendamustine hydrochloride (Treanda [®] , Bendeka [™])	Changed descriptors for diagnosis code ranges C81.10-C81.19, C81.20-C81.29, C81.30-C81.39, and C81.40-C81.49 for procedure codes J9033 (Treanda [®]) and C9399/J9999 (Bendeka [™]).
L36356	Bone Mineral Density Studies	Added diagnosis code ranges M84.751A – M84.752S, M84.754A – M84.755S, and M84.757A – M84.758S for procedure codes G0130, 77078, 77080, 77081, 77085, and 76977.

LCD database ID number	LCD title	2017 changes
L33904	B-Scan	Removed diagnosis codes E08.359, E09.359, E10.359, E11.359, and E13.359 for procedure codes 76510, 76512, and 76513. Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599, diagnosis code range E10.311-E10.359 to E10.311-E10.3599, diagnosis code range E11.311-E11.359 to E11.311-E11.3599, and diagnosis code range E13.311-E13.359 to E13.311-E13.3599 for procedure codes 76510, 76512, and 76513. Added diagnosis code ranges E08.37X1-E08.37X9, E09.37X1-E09.37X9, E10.37X1-E10.37X9, E11.37X1-E11.37X9, and E13.37X1-E13.37X9 for procedure codes 76510, 76512, and 76513.
L33812	Destruction by neurolytic agent; interdigital nerve of the foot—Morton's Neuroma	Added diagnosis code G57.63 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes 64632 and 64640. Added diagnosis code G57.53 to the "ICD-10 Codes that DO NOT Support Medical Necessity" section of the LCD for procedure codes 64632 and 64640.

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L33583	Diagnostic and Therapeutic Esophago-gastro-duodenoscopy	<p>Removed diagnosis codes F50.8, K52.2, K85.0, K85.9, and K90.4 for procedure codes 43233, 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43253, 43254, 43255, 43266, and 43270.</p> <p>Changed diagnosis code range K85.0-K85.9 to K85.00-K85.92 and diagnosis code range K90.0-K90.4 to K90.0-K90.49 for procedure codes 43233, 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43253, 43254, 43255, 43266, and 43270.</p> <p>Added diagnosis codes C49.A0, C49.A1, C49.A2, C49.A9, F50.81, F50.89, K52.21, K52.22, K52.29, K52.3, K52.831, K52.832, K52.838, K52.839, K55.30, K55.31, K55.32, K55.33, and Z79.84 for procedure codes 43233, 43235, 43236, 43237, 43238, 43239, 43241, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43253, 43254, 43255, 43266, and 43270.</p>

LCD database ID number	LCD title	2017 changes
L33671	Diagnostic Colonoscopy	<p>Removed diagnosis code K55.0 for procedure codes 44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, and 45398.</p> <p>Added diagnosis codes C49.A0, C49.A3, C49.A4, C49.A5, C49.A9, K55.011, K55.012, K55.019, K55.021, K55.022, K55.029, K55.031, K55.032, K55.039, K55.041, K55.042, K55.049, K55.051, K55.052, K55.059, K55.061, K55.062, K55.069, K55.30, K55.31, K55.32, and K55.33 for procedure codes 44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, and 45398.</p>

See **ICD-10**, next page

Medicare Learning Network®

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

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L33989	Docetaxel (Taxotere)	Added diagnosis code range C49.A0-C49.A9 for procedure code J9171.
L33990	Doxorubicin HCl	Added diagnosis code range C49.A0-C49.A9 for procedure code J9000.
L33722	Doxorubicin, Liposomal (Doxil/Lipodox)	Added diagnosis code range C49.A0-C49.A9 for procedure codes Q2049 and Q2050.
L33667	Duplex Scan of Lower Extremity Arteries	Removed diagnosis code I97.62 for procedure codes 93925 and 93926. Added diagnosis codes G97.61, G97.62, I97.620, I97.621, L76.31, L76.32, M96.840, M96.841, and S92.811A-S92.819S for procedure codes 93925 and 93926. Changed descriptors for diagnosis codes G97.51-G97.52, I97.618, L76.21-L76.22, and M96.830-M96.831 for procedure codes 93925 and 93926.
L33674	Duplex Scanning	Removed diagnosis codes K55.0 and R31.2 for procedure codes 93975 and 93976. Added diagnosis codes K55.011-K55.069, R31.21, and R31.29 for procedure codes 93975 and 93976.
L33669	Electro-cardiography	Added diagnosis code ranges I16.0-I16.9 and T88.53XA-T88.53XS for procedure codes 93000, 93005, and 93010.

LCD database ID number	LCD title	2017 changes
L33906	Epidural	Added diagnosis code range C49.A0-C49.A9 for procedure codes 62310, 62311, 64479, 64480, 64483 and 64484. Changed diagnosis code range G56.00-G56.92 to G56.00-G56.93, diagnosis code range G57.40-G57.42 to G57.40-G57.43, and diagnosis code range G57.70-G57.82 to G57.70-G57.83 for procedure codes 62310, 62311, 64479, 64480, 64483 and 64484.
L36276	Erythropoiesis Stimulating Agents	Added diagnosis code range C49.A0-C49.A9 for procedure codes J0881 (List 2) and J0885 (List 2).
L33723	Etoposide VP-16	Added diagnosis code range C49.A0-C49.A9 for procedure code J9181.
L33819	External Ocular Photography	Removed diagnosis code range S02.3XXA-S02.3XXS for procedure code 92285. Added diagnosis code range S02.30XA-S02.32XS for procedure code 92285.
L33997	Fluorescein Angiography	Removed diagnosis codes E08.359, E09.359, E10.359, E11.359, E13.359, H35.31, and H35.32 for procedure code 92235. Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599,

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L33997 (continued)	Fluorescein Angiography	diagnosis code range E10.311-E10.359 to E10.311-E10.3599, diagnosis code range E11.311-E11.359 to E11.311-E11.3599, and diagnosis code range E13.311-E13.359 to E13.311-E13.3599 for procedure code 92235. Added diagnosis code ranges E08.37X1-E08.37X9, E09.37X1-E09.37X9, E10.37X1-E10.37X9, E11.37X1-E11.37X9, E13.37X1-E13.37X9, H35.3110-H35.3194, and H35.3210-H35.3293 for procedure code 92235.
L33670	Fundus Photography	Removed diagnosis codes E08.359, E09.359, E10.359, E11.359, E13.359, H34.811, and H34.839 under the “Limitations” section of the LCD for procedure code 92250. Removed diagnosis codes E08.359 and E09.359 under the “ICD-10 Codes that Support Medical Necessity” section of the LCD for CPT® code 92250. Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599, diagnosis code range E10.311-E10.359 to E10.311-E10.3599,

LCD database ID number	LCD title	2017 changes
L33670 (continued)	Fundus Photography	diagnosis code range E11.311-E11.359 to E11.311-E11.3599, diagnosis code range E13.311-E13.359 to E13.311-E13.3599, and diagnosis code range H34.811-H34.839 to H34.8110-H34.8392 under the “Limitations” section of the LCD for procedure code 92250. Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599 and diagnosis code range E09.311-E09.359 to E09.311-E09.3599 under the “ICD-10 Codes that Support Medical Necessity” section of the LCD for CPT® code 92250. Added diagnosis code ranges E08.37X1-E08.37X9, E09.37X1-E09.37X9, E10.37X1-E10.37X9, E11.37X1-E11.37X9, E13.37X1-E13.37X9 under the “Limitations” section of the LCD for procedure code 92250. Added diagnosis code ranges E08.37X1-E08.37X9 and E09.37X1-E09.37X9 under the “ICD-10 Codes that Support Medical Necessity” section of the LCD for CPT® code 92250.
L33726	Gemcitabine (Gemzar)	Added diagnosis code range C49.A0-C49.A9 for procedure code J9201.

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L34003	Hepatitis B Surface Antibody and Surface Antigen	Removed diagnosis codes R82.7 and Z22.51 for procedure code 87340. Added diagnosis code range R82.71-R82.79 for procedure code 87340.
L33908	High Sensitivity C-Reactive Protein (hsCRP)	Removed diagnosis code E78.0 for procedure code 86141. Added diagnosis codes E78.00 and E78.01 for procedure code 86141.
L33377	Implantable Miniature Telescope (IMT)	Removed diagnosis code H35.31 for procedure codes C1840 and 0308T. Added diagnosis code range H35.3110-H35.3194 for procedure codes C1840 and 0308T.
L33909	Incision and Drainage of Abscess of Skin, Subcutaneous and Accessory Structures	Removed diagnosis code N61 for procedure codes 10060 and 10061. Added diagnosis codes N61.0 and N61.1 for procedure codes 10060 and 10061.
L33912	Injection of Trigger Points	Added diagnosis code M62.84 for procedure codes 20552 and 20553
L34007	Intravenous Immune Globulin	Added diagnosis code G61.82 for procedure codes J1459, J1556, J1557, J1561, J1566, J1568, J1569, J1572 and J1575.

LCD database ID number	LCD title	2017 changes
L33504	Intravitreal Bevacizumab (Avastin®)	Removed diagnosis codes E08.321, E08.331, E08.341, E08.351, E08.359, E09.321, E09.331, E09.341, E09.351, E09.359, E10.321, E10.331, E10.341, E10.351, E10.359, E11.321, E11.331, E11.341, E11.351, E11.359, E13.321, E13.331, E13.341, E13.351, E13.359, and H35.32 for procedure codes C9257, J3490, and J7999. Added diagnosis code ranges E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E08.3521-E08.3523, E08.3531-E08.3533, E08.3541-E08.3543, E08.3591-E08.3593, E09.3211-E09.3213, E09.3311-E09.3313, E09.3411-E09.3413, E09.3511-E09.3513, E09.3521-E09.3523, E09.3531-E09.3533, E09.3541-E09.3543, E09.3591-E09.3593, E10.3211-E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E10.3521-E10.3523, E10.3531-E10.3533, E10.3541-E10.3543, E10.3591-E10.3593, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.3513, E11.3521-E11.3523, E11.3531-E11.3533, E11.3541-E11.3543, E11.3591-E11.3593, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.3513, E13.3521-E13.3523,

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L33504 (continued)	Intravitreal Bevacizumab (Avastin®)	E13.3531-E13.3533, E13.3541-E13.3543, E13.3591-E13.3593, H35.3210-H35.3213, H35.3220-H35.3223, and H35.3230-H35.3233 for procedure codes C9257, J3490, and J7999. Changed diagnosis code range H34.811-H34.819 to H34.8110-H34.8192 and diagnosis code range H34.831-H34.839 to H34.8310-H34.8392 for procedure codes C9257, J3490, and J7999.
L34011	Ionized Calcium	Changed diagnosis code range K85.0-K85.9 to K85.00-K85.92 for procedure code 82330.
L33917	Laser Trabeculoplasty	Removed diagnosis code range H40.11X0-H40.11X4 for procedure code 65855. Added diagnosis code range H40.1110-H40.1194 for procedure code 65855.
L34012	Leucovorin (Wellcovorin®)	Added diagnosis code range C49.A0-C49.A9 for procedure code J0640.
L33381	Low Density Lipoprotein (LDL) Apheresis	Removed diagnosis code E78.0 for procedure code 36516. Added diagnosis codes E78.00 and E78.01 for procedure code 36516.
L33919	Macugen (pegaptanib sodium injection)	Removed diagnosis codes E08.321, E08.331, E08.341, E08.351, E10.321, E10.331, E10.341, E10.351, E11.321,

LCD database ID number	LCD title	2017 changes
L33919 (continued)	Macugen (pegaptanib sodium injection)	E11.331, E11.341, E11.351, E13.321, E13.331, E13.341, E13.351, and H35.32 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure code J2503. Added diagnosis code ranges E08.3211-E08.3213, E08.3311-E08.3313, E08.3411-E08.3413, E08.3511-E08.3513, E10.3211-E10.3213, E10.3311-E10.3313, E10.3411-E10.3413, E10.3511-E10.3513, E11.3211-E11.3213, E11.3311-E11.3313, E11.3411-E11.3413, E11.3511-E11.3513, E13.3211-E13.3213, E13.3311-E13.3313, E13.3411-E13.3413, E13.3511-E13.3513, H35.3210-H35.3213, H35.3220-H35.3223, and H35.3230-H35.3233 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure code J2503. Removed diagnosis code H35.31 under the "ICD-10 Codes that DO NOT Support Medical Necessity" section of the LCD for procedure code J2503. Added diagnosis code ranges H35.3110-H35.3114, H35.3120-H35.3124, H35.3130-H35.3134, H35.3190-H35.3194 under the "ICD-10 Codes that DO NOT Support Medical Necessity" section of the LCD for procedure code J2503.

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L34014	Magnesium	<p>Removed diagnosis code K52.2 for procedure code 83735.</p> <p>Added diagnosis codes K52.21-K52.29, K52.831-K52.839, and M62.84 for procedure code 83735.</p> <p>Changed diagnosis code range K85.0-K87 to K85.00-K87 for procedure code 83735.</p> <p>Changed descriptor for diagnosis code range P03.810-P03.89 for procedure code 83735.</p>
L33618	Major Joint Replacement (Hip and Knee)	<p>Removed diagnosis code ranges T84.040A-T84.040S and T84.041A-T84.041S for procedure codes 27130, 27132, 27134, 27137, and 27138.</p> <p>Added diagnosis code ranges M84.750A-M84.750S, M84.751A-M84.751S, M84.752A-M84.752S, M84.753A-M84.753S, M84.754A-M84.754S, M84.755A-M84.755S, M84.756A-M84.756S, M84.757A-M84.757S, M84.758A-M84.758S, M84.759A-M84.759S, M97.01XA-M97.01XS, and M97.02XA-M97.02XS for procedure codes 27130, 27132, 27134, 27137, and 27138.</p>

LCD database ID number	LCD title	2017 changes
L33618 (continued)	Major Joint Replacement (Hip and Knee)	<p>Removed diagnosis code ranges T84.042A-T84.042S and T84.043A-T84.043S for procedure codes 27445, 27447, 27486, and 27487.</p> <p>Added diagnosis code ranges M97.11XA-M97.11XS and M97.12XA-M97.12XS for procedure codes 27445, 27447, 27486, and 27487.</p>
L33920	Mastoidectomy Cavity Debridement	Added diagnosis code range H90.A11-H90.A32 for procedure codes 69220 and 69222.
L34859	Nerve Conduction Studies and Electromyography	<p>Added diagnosis code M62.84 for procedure codes 51785, 92265, 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95873, 95874, 95885, 95886, 95887, 95907, 95908, 95909, 95910, 95911, 95912, 95913, 95933, and 95937.</p> <p>Changed diagnosis code range G56.00-G56.02 to G56.00-G56.03 for procedure code 95905.</p>
L33923	Noninvasive Ear or Pulse Oximetry For Oxygen Saturation	Added diagnosis code range I16.0-I16.9 for procedure codes 97460, 97461, and 97462.
L33693	Non-Invasive Evaluation of Extremity Veins	Changed descriptor for diagnosis code range T82.817A-T82.818S for procedure codes 93965, 93970, and 93971.

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L33695	Non-invasive Extracranial Arterial Studies	<p>Added diagnosis codes I72.5, I72.6, and I77.75 for procedure codes 93880 and 93882.</p> <p>Removed diagnosis codes H34.811-H34.839 for procedure codes 93880 and 93882 as they are not applicable to this LCD. (Not related to ICD-10 Update)</p> <p>Changed diagnosis code range H34.00-H34.9 to H34.00-H34.239, and H34.9 for procedure codes 93880 and 93882..</p>
L33696	Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries	<p>Removed diagnosis codes I97.62 and T85.81XA for procedure codes 93922, 93923, and 93924.</p> <p>Changed diagnosis code range I97.610-I97.62 to I97.610-I97.618 for procedure codes 93922, 93923, and 93924.</p> <p>Changed diagnosis code range T85.81XA-T85.9XXS to T85.810A-T85.9XXS for procedure codes 93922, 93923, and 93924.</p> <p>Added diagnosis codes G97.61, G97.62, H59.331-H59.339, H59.341-H59.349, I77.76, I77.77, I97.620-I97.621, I97.630-I97.638, J95.860, J95.861, K91.870, K91.871, L76.31, L76.32, M96.840, M96.841, N99.840, and N99.841 for procedure codes 93922, 93923, and 93924. 93922, 93923, and 93924.</p>

LCD database ID number	LCD title	2017 changes
L33696 (continued)	Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries	<p>Changed descriptors for diagnosis codes D78.22, G97.51-G97.52, H59.329, H95.42, I97.610-I97.618, J95.830-J95.831, K91.840-K91.841, L76.21-L76.22, M96.831, N99.820-N99.821, and T83.81XA for procedure codes 93922, 93923, and 93924.</p>
L33705	Ocular Photodynamic Therapy (OPT) with Verteporfin	<p>Removed diagnosis code H35.32 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes 67221, 67225, and J3396.</p> <p>Added diagnosis code ranges H35.3210-H35.3213, H35.3220-H35.3223, H35.3230-H35.3233, and H35.3290 - H35.3293 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes 67221, 67225, and J3396.</p> <p>Removed diagnosis code H35.31 under the "ICD-10 Codes that DO NOT Support Medical Necessity" section of the LCD for procedure codes 67221, 67225, and J3396.</p> <p>Added diagnosis code ranges H35.3110-H35.3114, H35.3120-H35.3124, H35.3130-H35.3134, H35.3190-H35.3194 under the "ICD-10 Codes that DO NOT Support Medical Necessity" section of the LCD for procedure codes 67221, 67225, and J3396.</p>

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L34017	Ophthalmoscopy	<p>Removed diagnosis codes E08.359, E09.359, E10.321, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.321, E13.331, E13.339, E13.341, E13.349, E13.351, and E13.359 for procedure codes 92225 and 92226</p> <p>Added diagnosis code ranges E10.3211-E10.3219, E11.3211-E11.3219, E11.3291-E11.3299, and E13.3211-E13.3219 for procedure codes 92225 and 92226.</p> <p>Changed diagnosis code ranges E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599, diagnosis code range E10.331-E10.339 to E10.3311-E10.3399, diagnosis code range E10.341-E10.349 to E10.3411-E10.3499, diagnosis code range E10.351-E10.359 to E10.3511-E10.3599, diagnosis code range E11.331-E11.339 to E11.3311-E11.3399, diagnosis code range E11.341-E11.349 to E11.3411-E11.3499, diagnosis code range E11.351-E11.359 to E11.3511-E11.3599, diagnosis code range E13.331-E13.339 to E13.3311-E13.3399, diagnosis code range E13.341-E13.349 to E13.3411-E13.3499, and</p>

LCD database ID number	LCD title	2017 changes
L34017 (continued)	Ophthalmoscopy	diagnosis code range E13.351-E13.359 to E13.3511-E13.3599 for procedure codes 92225 and 92226.
L33926	Oprelvekin (Neumega®)	Added diagnosis code range C49.A0-C49.A9 for procedure code J2355.
L33928	Osteogenic Stimulation	Removed diagnosis code range T84.040A-T84.049S for procedure codes 20974 and 20975.
L33747	Pegfilgrastim (Neulasta®)	Added diagnosis code range C49.A0-C49.A9 for procedure code J2505.
L33933	Peripheral Nerve Blocks	<p>Removed new diagnosis code D47.Z2 from diagnosis code range D47.Z1-D47.Z9 for procedure codes 64400, 64402, 64405, 64413, 64415, 64416, 64417, 64418, 64420, 64421, 64425, 64430, 64445, 64446, 64447, 64448, 64449, and 64450 as it is not applicable to this LCD.</p> <p>Changed diagnosis code range G56.00-G56.02 to G56.00- G56.03, diagnosis code range G56.40-G56.42 to G56.40-G56.43, diagnosis code range G57.10-G57.12 to G57.10-G57.13, diagnosis code range G57.70-G57.72 to G57.70- G57.73, and diagnosis code range G57.90-G57.92 to G57.90-G57.93 for procedure codes 64402, 64405, 64413, 64415, 64416, 64417, 64418, 64420, 64421, 64425, 64430, 64445, 64446, 64447, 64448, and 64449.</p>

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L33933 (continued)	Peripheral Nerve Blocks	Changed diagnosis code range G56.00-G56.02 to G56.00- G56.03, diagnosis code range G57.10-G57.12 to G57.10-G57.13 and G57.50-G57.52 to G57.50-G57.53 for procedure code 64450. Changed diagnosis code range G57.60-G57.62 to G57.60-G57.63 for procedure code 64455.
L33935	Post-Voiding Residual Ultrasound	Changed descriptor for diagnosis code N40.1 for procedure code 51798.
L33252	Psychiatric Diagnostic Evaluation and Psychotherapy Services	Removed diagnosis codes F32.8, F34.8, F42, and F50.8 for procedure codes 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, and 90853. Changed diagnosis code range F32.0-F32.8 to F32.0-F32.89, diagnosis code range F34.0-F34.8 to F34.0-F34.89, diagnosis code range F42-F43.8 to F42.2-F43.8, and diagnosis code range F50.00-F50.8 to F50.00-F50.89 for procedure codes 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, and 90853.

LCD database ID number	LCD title	2017 changes
L34520	Psychological and Psychological Tests	Removed diagnosis codes I69.01, I69.11, I69.21, I69.31, I69.81, and I69.91 for procedure codes 96101, 96102, 96103, 96118, 96119, 96120, and G0451. Changed diagnosis code range I69.01-I69.020 to I69.010-I69.020 and diagnosis code range I69.11-I69.122 to I69.110-I69.122 for procedure codes 96101, 96102, 96103, 96118, 96119, 96120, and G0451. Added diagnosis code ranges I69.210-I69.219, I69.310-I69.319, I69.810-I69.819, and I69.910-I69.919 for procedure codes 96101, 96102, 96103, 96118, 96119, 96120, and G0451.
L33407	Ranibizumab (Lucentis®)	Removed diagnosis codes E08.321, E08.331, E08.341, E08.351, E09.321, E09.331, E09.341, E09.351, E10.321, E10.331, E10.341, E10.351, E11.321, E11.331, E11.341, E11.351, E13.321, E13.331, E13.341, E13.351, H34.811,

See ICD-10, next page

New CERT documentation contractor effective October 14, 2016

AdvanceMed, the current comprehensive error rate testing (CERT) review contractor will also be operating the CERT documentation center, effective October 14,

2016. Beginning October 7, 2016, all CERT inquires and medical records should be sent to AdvanceMed. For more information, visit the [CERT website](#).

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L33407 (continued)	Ranibizumab (Lucentis®)	H34.819, H34.831, H34.839, and H35.32 for procedure code J2778. Added diagnosis code ranges E08.3211-E08.3219, E08.3311-E08.3319, E08.3411-E08.3419, E08.3511-E08.3519, E09.3211-E09.3219, E09.3311-E09.3319, E09.3411-E09.3419, E09.3511-E09.3519, E10.3211-E10.3219, E10.3311-E10.3319, E10.3411-E10.3419, E10.3511-E10.3519, E11.3211-E11.3219, E11.3311-E11.3319, E11.3411-E11.3419, E11.3511-E11.3519, E13.3211-E13.3219, E13.3311-E13.3319, E13.3411-E13.3419, E13.3511-E13.3519, and H35.3210-H35.3293 for procedure code J2778. Changed diagnosis code range H34.811-H34.819 to H34.8110-H34.8192 and diagnosis code range H34.831-H34.839 to H34.8310-H34.8392 for procedure code J2778.
L33715	Renal Angiography	Removed diagnosis code K55.0 for procedure codes 36251, 36252, 36253, and 36254. Added diagnosis code range K55.011-K55.049 for procedure codes 36251, 36252, 36253, and 36254.

LCD database ID number	LCD title	2017 changes
L33745	Respiratory Therapeutic Services	Removed diagnosis code J98.5 for procedure codes G0237, G0238, and G0239. Changed diagnosis code range J98.5-J98.9 to J98.51-J98.9 for procedure codes G0237, G0238, and G0239..
L33746	Rituximab (Rituxan®)	Changed descriptor for diagnosis code range C81.40-C81.49 for procedure code J9310.
L33751	Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	Removed diagnosis codes E08.359, E09.359, E10.359, E11.359, E13.359, H34.811, and H34.839 under the "Limitations" section of the LCD for procedure codes 92133 and 92134. Removed diagnosis codes E08.359, E09.359, E10.359, E11.359, E13.359, H34.811, H34.819, H34.831, and H34.839 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes 92133 and 92134. Changed Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599, diagnosis code range E10.311-E10.359 to E10.311-E10.3599, diagnosis code range E11.311-E11.359 to E11.311-E11.3599, diagnosis code range E13.311-E13.359 to E13.311-E13.3599,

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L33751 (continued)	Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)	<p>and diagnosis code range H34.811-H34.839 to H34.8110-H34.8392 under the "Limitations" section of the LCD for procedure codes 92133 and 92134.</p> <p>Changed diagnosis code range E08.311-E08.359 to E08.311-E08.3599, diagnosis code range E09.311-E09.359 to E09.311-E09.3599, diagnosis code range E10.311-E10.359 to E10.311-E10.3599, diagnosis code range E11.311-E11.359 to E11.311-E11.3599, diagnosis code range E13.311-E13.359 to E13.311-E13.3599, diagnosis code range H34.811-H34.819 to H34.8110-H34.8192, and diagnosis code range H34.831-H34.839 to H34.8310-H34.8392 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for procedure codes 92133 and 92134.</p> <p>Added diagnosis code ranges E08.37X1-E08.37X9, E09.37X1-E09.37X9, E10.37X1-E10.37X9, E11.37X1-E11.37X9, and E13.37X1-E13.37X9 under the "Limitations" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD for procedure codes 92133 and 92134.</p> <p>Added diagnosis code Z79.84 for procedure code 92134.</p>

LCD database ID number	LCD title	2017 changes
L34022	Serum Phosphorus	<p>Removed diagnosis code K90.4 and Z98.89 for procedure code 84100.</p> <p>Changed diagnosis code range K90.0-K90.4 to K90.0-K90.49 for procedure code 84100.</p> <p>Added diagnosis codes M62.84 and Z98.890 for procedure code 84100.</p>
L36035	Spinal Cord Stimulation for Chronic Pain	<p>Changed diagnosis code range G56.40-G56.42 to G56.40- G56.43, diagnosis code range G56.80-G56.92 to G56.80-G56.93, diagnosis code range G57.70-G57.72 to G57.70-G57.73, diagnosis code range G57.80-G57.82 to G57.80-G57.83, and diagnosis code range G57.90-G57.92 to G57.90-G57.93 for procedure codes 63650, 63655, 63661-63664, 63685, and 63688.</p> <p>Removed diagnosis code range T85.81XA-T85.89XS for procedure codes 63650, 63655, 63661-63664, 63685, and 63688.</p> <p>Added diagnosis range T85.810A-T85.898S for procedure codes 63650, 63655, 63661-63664, 63685, and 63688.</p>
L34023	Strapping	<p>Added diagnosis code range M21.611-M21.629 for procedure codes 29540 and 29550.</p> <p>Added diagnosis code range S92.811A-S92.819S for procedure codes 29540, 29550, and 29580.</p>

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L34025	Surgical Decompression for Peripheral Polyneuropathy	Added diagnosis code G61.82 for procedure codes 28035, 64702, 64704, 64708, 64712, 64714, 64722, 64726 and 64727.
L33411	Surgical Management of Morbid Obesity	Removed diagnosis code E78.0 for procedure codes 43644, 43645, 43770, 43775, 43845, 43846, and 43847. Changed diagnosis code range E78.0-E78.5 to E78.00-E78.5 for procedure codes 43644, 43645, 43770, 43775, 43845, 43846, and 43847.
L33754	Syphilis Test	Removed diagnosis code F32.8 for procedure codes 86592, 86593, and 86780. Added diagnosis codes F32.81 and F32.89 for procedure codes 86592, 86593, and 86780. Changed descriptor for diagnosis code P00.2 for procedure codes 86592, 86593, and 86780.
L33413	Therapy and Rehabilitation Services	Changed diagnosis code range G56.40-G56.42 to G56.40-G56.43, diagnosis code range G56.90-G56.92 to G56.90-G56.93, diagnosis code range G57.10-G57.12 to G57.10-G57.13, diagnosis code range G57.20-G57.22 to G57.20-G57.23,

LCD database ID number	LCD title	2017 changes
L33413 (continued)	Therapy and Rehabilitation Services	diagnosis code range G57.30-G57.32 to G57.30-G57.33, diagnosis code range G57.40-G57.42 to G57.40-G57.43, diagnosis code range G57.60-G57.62 to G57.60-G57.63, diagnosis code range G57.70-G57.72 to G57.70-G57.73, diagnosis code range G57.80-G57.82 to G57.80-G57.83 and diagnosis code range G57.90-G57.92 to G57.90-G57.93 for procedure code 97026. Added diagnosis code G61.82 for procedure code 97026. Removed diagnosis code Z98.89 for procedure code 97116. Added diagnosis code Z98.890 for procedure code 97116.
L34031	Total Calcium	Removed diagnosis codes K85.0, K85.9, and K90.4 for procedure code 82310. Changed diagnosis code range K85.0-K85.9 to K85.00-K85.92 and diagnosis code range K90.0-K90.4 to K90.0-K90.49 for procedure code 82310. Added diagnosis code M62.84 for procedure code 82310.

See ICD-10, next page

ICD-10

From previous page

LCD database ID number	LCD title	2017 changes
L33756	Transesophageal Echocardiogram	<p>Removed diagnosis code Q25.2 for procedure codes 93312, 93313, 93314, 93315, 93316, 93317, 93318, and 93355.</p> <p>Changed diagnosis code range Q20.0-Q25.2 to Q20.0-Q25.29 for procedure codes 93312, 93313, 93314, 93315, 93316, 93317, 93318, and 93355.</p> <p>Changed descriptors for diagnosis code ranges T82.827A-T82.827S, T82.837A-T82.837S, T82.847A-T82.847S, T82.857A-T82.857S, and T82.867A-T82.867S for procedure codes 93312, 93313, 93314, 93315, 93316, 93317, 93318, and 93355.</p>
L33768	Transthoracic Echocardiography (TTE)	<p>Removed diagnosis code Q25.2 for procedure codes 93306, 93307, and 93308.</p> <p>Changed diagnosis code range Q20.0-Q25.2 to Q20.0-Q25.29 for procedure codes 93306, 93307, and 93308.</p> <p>Changed diagnosis code range I77.71-I77.79 to I77.70-I77.79 for procedure codes 93306, 93307, and 93308.</p>

LCD database ID number	LCD title	2017 changes
L33768 (continued)	Transthoracic Echocardiography (TTE)	<p>Changed diagnosis code range I77.71-I77.79 to I77.70-I77.79 for procedure codes 93306, 93307, and 93308.</p> <p>Changed descriptors for diagnosis code ranges T82.827A-T82.827S, T82.837A-T82.837S, T82.847A-T82.847S, T82.857A-T82.857S, and T82.867A-T82.867S for procedure codes 93306, 93307, and 93308.</p>
L33963	Tympanometry	Added diagnosis code ranges H90.A11-H90.A32 and H93.A1-H93.A9 for procedure code 92567.
L34001	Vinorelbine Tartrate (Navelbine®)	Added diagnosis code range C49.A0-C49.A9 for procedure code J9390.
L33766	Visual Field Examination	Changed diagnosis code range E08.311-E08.36 to E08.311-E08.37X9 and diagnosis code range E09.311-E09.36 to E09.311-E09.37X9 for procedure codes 92081, 92082, and 92083.
L33967	Vitamin B12 Injections	Removed diagnosis code K90.4 for procedure code J3420. Changed diagnosis code range K90.0-K90.4 to K90.0-K90.49 for procedure code J3420.
L33771	Vitamin D; 25 hydroxy, includes fraction(s), if performed	Removed diagnosis code K90.4 for procedure code 82306. Changed diagnosis code range K90.0-K90.4 to K90.0-K90.49 for procedure code 82306.

Upcoming provider outreach and educational events

Topic: First Coast and CGS Administrators collaborative webinar: Glucose monitors and diabetic testing supplies

Date: Tuesday, November 8

Time: 12:30-2:00 p.m.

Type of Event: Webcast

<https://medicare.fcso.com/Events/0358258.asp>

Topic: Medicare Part B changes and regulations

Date: Wednesday, December 14

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

Type of Event: Webcast

<https://medicare.fcso.com/Events/0353644.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.fcsoiniversity.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, 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.



CMS MLN Connects® Provider eNews



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

MLN Connects® Provider eNews for September 29, 2016

MLN Connects® Provider eNews for September 29, 2016
[View this edition as a PDF](#)

Editor’s Note:

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. In this issue, learn about the new Medicare Beneficiary Identifier, and find out how to prepare.

News & Announcements

- Social Security Number Removal Initiative
- 2015 PQRS Feedback Reports and 2015 Annual QRURs Available
- IMPACT Act Cross-Setting Quality Measure on Major Falls: Comments due October 14
- New CERT Documentation Contractor Effective October 14
- Medicare EHR Requirements for 2016 Participation
- EHR Incentive Programs: 2016 Exclusions and Alternate Exclusions
- eCQM: Review and Comment on Proposed Specification Changes
- Updated ICD-10 Flexibility FAQs and 2017 Codes
- Medscape Article for CME Credit: Transforming Clinical Practice to Provide Patient-Centered Quality Care
- National Cholesterol Education Month and World Heart Day



Claims, Pricers & Codes

- Hospices: Hold on Claim Adjustments for Miscalculated Routine Home Care Days

Upcoming Events

- Emergency Preparedness Requirements Call — October 5
- IMPACT Act: Data Elements and Measure Development Call — October 13

- How to Report Across 2016 Medicare Quality Programs Call — November 1

Medicare Learning Network® Publications & Multimedia

- SNF Quality Reporting Program Webcast: Audio Recording and Transcript — New
- Dementia Care and QAPI Call: Audio Recording and Transcript — New
- PQRS Call Addendum — New
- Inpatient Psychiatric Facility Prospective Payment System Fact Sheet — Revised
- Medicare Enrollment for Physicians and Other Part B Suppliers Fact Sheet — Revised
- Medicare Enrollment for Institutional Providers Fact Sheet — Revised
- Safeguard Your Identity and Privacy Using PECOS Fact Sheet — Revised
- Revised “How to” Products Available in Hard Copy Format

Provider Compliance

- Evaluation and Management: Billing the Correct Level of Service

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® Provider eNews for October 6, 2016

MLN Connects® Provider eNews for October 6, 2016

[View this edition as a PDF](#) 

Editor's Note:

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. In this issue, learn about the new Medicare Beneficiary Identifier, and find out how to prepare.

News & Announcements

- Social Security Number Removal Initiative
- 2015 PQRS Feedback Reports and 2015 Annual QRURs Available
- IMPACT Act Cross-Setting Quality Measure on Major Falls: Comments due October 14
- New CERT Documentation Contractor Effective October 14
- Medicare EHR Requirements for 2016 Participation
- EHR Incentive Programs: 2016 Exclusions and Alternate Exclusions
- eCQM: Review and Comment on Proposed Specification Changes
- Updated ICD-10 Flexibility FAQs and 2017 Codes
- Medscape Article for CME Credit: Transforming Clinical Practice to Provide Patient-Centered Quality Care
- National Cholesterol Education Month and World Heart Day

Provider Compliance

- Evaluation and Management: Billing the Correct Level of Service

Claims, Pricers & Codes

- Hospices: Hold on Claim Adjustments for Miscalculated Routine Home Care Days

Upcoming Events

- Emergency Preparedness Requirements Call — October 5
- IMPACT Act: Data Elements and Measure Development Call — October 13
- How to Report Across 2016 Medicare Quality Programs Call — November 1

Medicare Learning Network® Publications & Multimedia

- SNF Quality Reporting Program Webcast: Audio Recording and Transcript — New
- Dementia Care and QAPI Call: Audio Recording and Transcript — New
- PQRS Call Addendum — New
- Inpatient Psychiatric Facility Prospective Payment System Fact Sheet — Revised
- Medicare Enrollment for Physicians and Other Part B Suppliers Fact Sheet — Revised
- Medicare Enrollment for Institutional Providers Fact Sheet — Revised
- Safeguard Your Identity and Privacy Using PECOS Fact Sheet — Revised
- Revised "How to" Products Available in Hard Copy Format

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

Take action to combat the flu

Now is the perfect time for providers to vaccinate Medicare beneficiaries, as it can take two weeks after vaccination to develop antibodies that protect against seasonal influenza. As a health care provider, you play an important role in setting an example by getting yourself vaccinated and recommending and promoting influenza vaccination.

MLN Connects® Provider eNews for October 13, 2016

MLN Connects® Provider eNews for October 13, 2016

[View this edition as a PDF](#) 

News & Announcements

- New Data to Increase Transparency on Medicare Hospice Payments
- SNF Value-Based Purchasing Program: Confidential Feedback Reports Available
- IMPACT Act Cross-Setting Quality Measure on Major Falls: Comments due October 14
- EHR Incentive Programs: Review Resources on 2016 Program Requirements
- Protect Your Patients from Influenza this Season

Provider Compliance

- Reporting Fraud to the Office of the Inspector General

Upcoming Events

- CMS Rural Health Council Solutions Summit — October 19
- 2015 Supplemental QRUR Physician Feedback Program Call — October 20
- Long-Term Care Facilities: Reform of Requirements Call — October 27
- How to Report Across 2016 Medicare Quality Programs Call — November 1

- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 2

Medicare Learning Network® Publications & Multimedia

- Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
- Learning Management and Product Ordering System FAQs Booklet — New
- SNF Value-Based Purchasing Program Call: Audio Recording and Transcript — New
- 2015 Annual QRURs Webcast: Audio Recording and Transcript — New
- Medicare Basics: Commonly Used Acronyms Educational Tool — Revised
- Preventive Services Educational Tool — Revised
- Fraud & Abuse Educational Products — Revised
- Screening Pap Tests and Pelvic Examinations Booklet — Reminder
- Give us Your Feedback

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® Provider eNews for October 20, 2016

MLN Connects® Provider eNews for October 20, 2016

[View this edition as a PDF](#) 

News & Announcements

- CMS Announces New Initiative to Increase Clinician Engagement
- Medicare's Investment in Primary Care Shows Progress
- Physician Compare Preview Period Ends November 11
- Value Modifier: Informal Review Request Period Open through November 30
- 2015 Supplemental Quality and Resource Use Reports Available
- Medicare Open Enrollment Information for your Patients

Provider Compliance

- Importance of Documentation

Claims, Pricers & Codes

- October 2016 OPPS Pricer File Update

Upcoming Events

- Long-Term Care Facilities: Reform of Requirements Call — October 27

- How to Report Across 2016 Medicare Quality Programs Call — November 1
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 2
- Quality Payment Program Final Rule Call — November 15
- Home Health Quality Reporting Program Provider Training — November 16 and 17

Medicare Learning Network® Publications & Multimedia

- Provider Compliance Fact Sheets — New
- Emergency Preparedness Requirements Call: Audio Recording and Transcript — New
- Evaluation and Management Services Guide — Revised
- Hospice Payment System Booklet — Revised
- Provider Compliance Fact Sheets — Revised
- Continuing Education Credits for Web-Based Training Courses

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

Email: FloridaB@fcso.com
Online form: <http://medicare.fcso.com/Feedback/161670.asp>

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

Customer service

866-454-9007

877-660-1759 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

866-454-9007

877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614

877-660-1759 (TTY)

The SPOT help desk

855-416-4199

Email: FCSOSPOTHelp@FCSO.com

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

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

Provider enrollment

Provider Enrollment

P.O. Box 44021

Jacksonville, FL 32231-4021

Medical policy

Medical Policy and Procedure

P.O. Box 2078

Jacksonville, FL 32231-0048

Email: medical.policy@fcsso.com

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

<http://medicare.fcsso.com>

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

Centers for Medicare & Medicaid Services

<http://www.cms.gov>

First Coast University

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

Beneficiaries

Centers for Medicare & Medicaid Services

<https://www.medicare.gov>

Phone numbers

Customer service

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

Education event registration hotline

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

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

855-416-4199
email: FCSOSPOTHelp@FCSO.com

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

Provider enrollment

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

Medical policy

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

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
<http://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>Part B subscription – The Medicare Part B jurisdiction N publications, in both Spanish and English, are available free of charge online at http://medicare.fcso.com/Publications_B/index.asp (English) or http://medicareespanol.fcso.com/Publicaciones/ (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>2016 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2016, are available free of charge online at http://medicare.fcso.com/Data_files/ (English) or http://medicareespanol.fcso.com/Fichero_de_datos/ (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>Note: 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: English [] Español []				
<i>Please write legibly</i>			Subtotal	\$
			Tax (add % for your area)	\$
			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)

TABLE OF CONTENTS

OVERVIEW.....	1
NAVIGATING THE TEMPLATE.....	1
TEMPLATE CONSTRAINTS.....	2
FIELD DEFINITIONS.....	3
TEMPLATE REQUIREMENTS.....	3

LIST OF FIGURES

Figure 1 – The CLFS template view using Notepad..... 3

Figure 2 – The CLFS template view using MS Excel..... 3

1 OVERVIEW

Section 1834A of the Social Security Act (the Act), added by Section 216 of the Protecting Access to Medicare Act of 2014 (PAMA), significantly changes how Medicare payment rates are set for clinical diagnostic laboratory tests (CDLTs) paid under the Medicare Clinical Laboratory Fee schedule (CLFS). In general, the Centers for Medicare & Medicaid Services (CMS) will establish Medicare payment rates for CDLTs on the Clinical Laboratory Fee Schedule (CLFS) based on the weighted median of the rates that private payors pay for the test during a specified data collection period. Applicable laboratories must collect applicable information (that is, private payor rates and associated volume for covered tests identified by HCPCS codes) for the period beginning January 1, 2016, through June 30, 2016. Applicable laboratories must report their data to CMS beginning January 1, 2017, through March 31, 2017. CMS will use this data to calculate payment rates for the calendar year 2018 CLFS update.

This .CSV (Comma Separated Values) template can be populated by system generation, populated through a text editor, or with a tool such as MS Excel.

The CLFS data reporting template provides the required data fields for reporting applicable information for the CLFS private payor rate-based system. “Comma Separated Value” (.csv) is the available format for data submission through a file upload process. Alternatively, data may be submitted through an online interface. Data must be reported to CMS through the Fee-For-Service Data Collection System (FFSDCS) CLFS System at <https://portal.cms.gov>. For detailed guidance on data collection and reporting, refer to [Medicare Part B Clinical Laboratory Fee Schedule: Guidance to Laboratories for Collecting and Reporting Data for the Private Payor Rate-Based Payment System](#).

NOTE: The requirements under Section 1834A of the Act and the data reported on this form are exempt from the requirements of the Paperwork Reduction Act (Chapter 35 of Title 44, United States Code).

2 NAVIGATING THE TEMPLATE

- The template file is named “CLFS-Lab Data-Collection-Final.csv”. You can access it in the Downloads section on the [Clinical Laboratory Fee Schedule](#) web page.
- The CLFS .csv template may be opened using a text editor, such as Notepad or a spreadsheet application such as MS Excel.

- The template opened with Notepad:

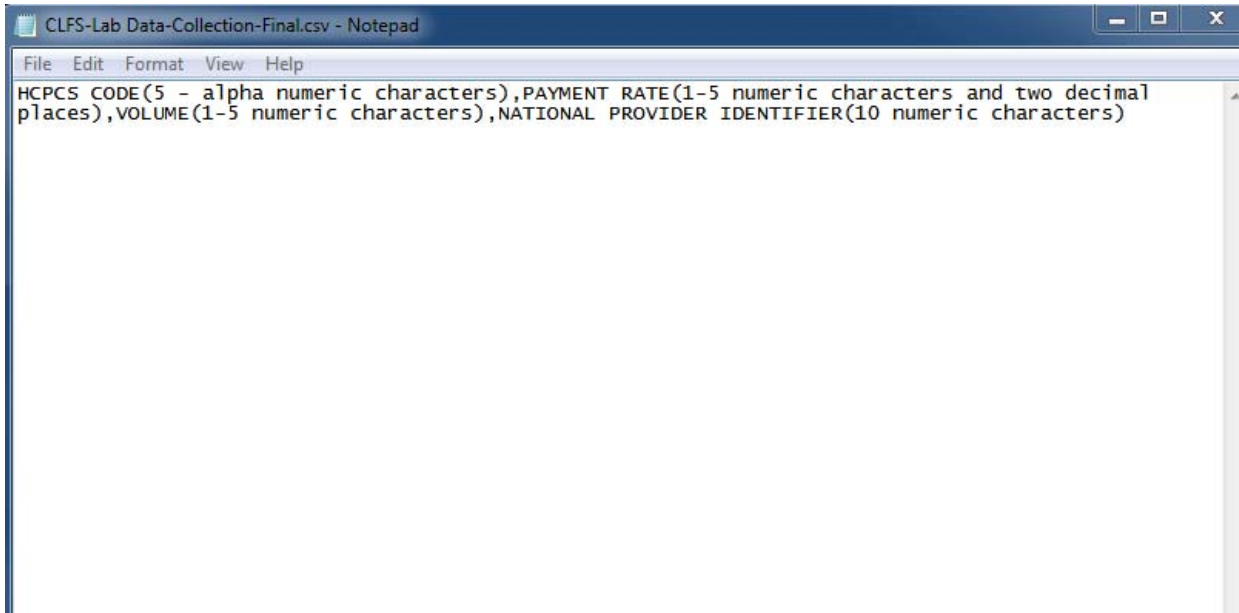


Figure 1 – The CLFS template view using Notepad

- The template opened with MS Excel:

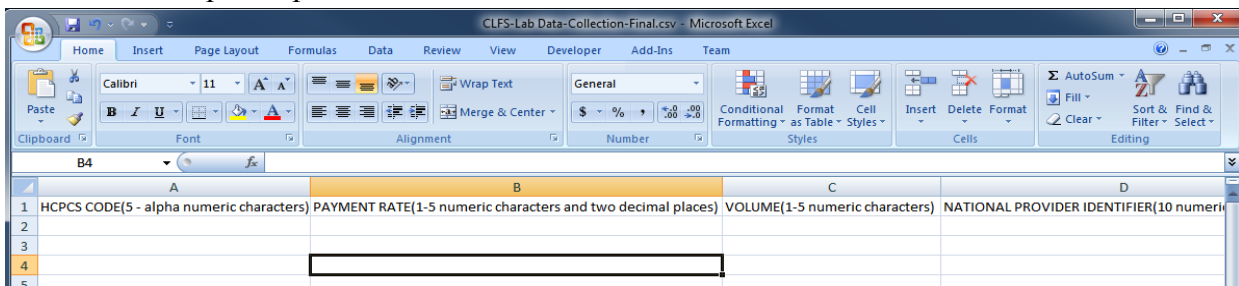


Figure 2 – The CLFS template view using MS Excel

3 TEMPLATE CONSTRAINTS

- The template may be populated through system generated content or manually via an online interface
- Do not manipulate the Header Row (Row 1)
- Report data in the order specified by the template
- A comma must separate each value
- The CLFS System will not recognize any formatting or manipulation in Excel
- The CLFS System will validate data fields as defined by “Field Definition” in Table 1

4 FIELD DEFINITIONS

You must enter properly formatted data through the provided template.

Table 1: Field Definitions for CLFS Template

Field Name	Field Definition	Value Values	Required Field
HCPCS Code	Standardized coding system used to represent medical procedures performed on a patient or non-physician services.	5 alphanumeric characters are accepted.	Yes
Payment Rate	Each unique private payor rate for each test.	Only numeric values are accepted. Values include numeric characters with 2 decimal places. Formatted as XXXXX.XX.	Yes
Volume	Number of lab tests paid at each unique private payor rate.	Only positive numeric values including 0 are accepted. Values include numeric characters, no decimal places. Formatted as XXXXX.	Yes
National Provider Identifier	A unique 10-digit identification number required by HIPAA for all health care transactions by providers in the United States.	10 numeric digits are accepted.	Yes

5 TEMPLATE REQUIREMENTS

1. Do not add additional columns to the template.
2. Do not add, remove, or otherwise change columns or column headings within the template.
3. Do not submit blank rows between data entries. You must submit all data in contiguous rows.