# Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

*A Newsletter for MAC Jurisdiction N Providers* January 2017


## In this issue



# What can SPOT do for you – eligibility and benefits information

### Use eligibility and benefits to prevent denied claims

Snowbirds, splitting their year between Florida and places north, can complicate matters for providers billing Medicare for services provided to these beneficiaries. When they receive preventative services from their physicians in their summer hometowns, and then visit Florida doctors during winter months, some beneficiaries may not be eligible for services and medical tests typically covered by Medicare.

"With our snowbirds, we have to stay on top of their eligibility status," said one Medicare billing manager. "Many beneficiaries aren't aware they enrolled in a Medicare plan different from the traditional plan. They know they have Medicare and that's it. Having fast access to Medicare eligibility and secondary payer information helps us file clean, accurate claims and get reimbursed sooner."

First Coast Service Options Inc. *offers such access through SPOT* (Secure Provider Online Tool). With SPOT, providers may access Part A and Part B eligibility status as well as benefit eligibility for preventive services, deductibles, therapy caps, inpatient, hospice and home health, Medicare secondary payer (MSP), and plan coverage data categories.

### Viewing preventive service information before the patient arrives

Preventive services data includes both professional and technical services along with the next eligible dates or previous date the service was provided. SPOT eligibility reports show preventive services that are gender-specific to each beneficiary. Preventive services data *viewable in SPOT* includes:

- Abdominal aortic aneurysm ultrasound screening
- Annual depression screening
- Annual wellness visit
- Bone density measurements
- Cardiovascular disease screening
- Colorectal cancer screening
- Diabetes screening tests
- Fecal occult blood test
- Glaucoma screening
- High intensity behavioral counseling
- Initial preventive physical examination

See **SPOT**, page 30

# Contents




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:**

Terri Drury
Maria Murdoch
Mark Willett
Robert Petty

Fax comments about this publication to:

**Medicare Publications**
**904-361-0723**


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

# 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.

Ambulatory Surgical Center

# January 2017 update of the ASC payment system

## Provider types affected

This *MLN Matters*® article is intended for ambulatory surgical centers (ASCs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

## Provider action needed

Change request (CR) 9923 updates the ASC payment system, the payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC drug files), the ASC payment indicator (PI) file, and the 2017 ASC payment rates for covered surgical and ancillary services (ASCFS file). Make sure that your billing staffs are aware of these changes that are effective January 1, 2017.

## Background

CR 9923 describes changes to, and billing instructions for, various payment policies implemented in the January 2017 ASC payment system update, including:

1. The 2017 payment rates for separately payable drugs and biologicals along with descriptors for newly created level II HCPCS codes for drugs and biologicals (ASC drug files), and
2. The 2017 ASC payment rates for covered surgical and ancillary services (ASCFS file). It also includes the 2017 ASC code pair file, and as appropriate, also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare physician fee schedule (MPFS). The payment files provided in CR 9923 reflect the most recent changes to 2017 MPFS payment.

## Key updates

### 1. New device pass-through policies

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the outpatient prospective payment system (OPPS), categories of devices are eligible for transitional pass-through payments for at least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that the Centers for Medicare & Medicaid Services (CMS) create additional categories for transitional pass-through payment of new medical devices not described by existing (or previously existing) categories of devices.

Medicare implemented this policy in the 2008 revised ASC payment system. Therefore, additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the OPPS.

In the 2017 OPPS/ASC final rule with comment period that was published in the *Federal Register* November 14, 2016, CMS adopted a policy to revise the pass-through payment time period by having the pass-through start date begin with the date of first payment and by allowing pass-through status to expire on a quarterly basis, such that the duration of device pass-through payment will be as close to three years as possible. This policy is applicable in both the OPPS and ASC payment systems. Refer to the 2017 OPPS/ASC final rule with comment period at *https://www.gpo.gov/fdsys/pkg/FR-2016-11-14/pdf/2016-26515.pdf* for complete details about these policy changes for device pass-through that will become effective January 1, 2017.

The three device categories that are currently eligible for pass-through payment in the OPPS and ASC payment systems are: (1) HCPCS code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser); (2) HCPCS code C2613 (Lung biopsy plug with delivery system); and (3) HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system). These codes and their ASC payment indicator are listed in Addendum BB at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

### 2. Argus retinal prosthesis add-on code (C1842)

Effective October 1, 2013, and expiring December 31, 2015, one device, listed in Table 1 (C1841 - Retinal prosthesis, includes all internal and external components) was eligible for pass-through payment in the OPPS and ASC payment systems. After pass-through status expires for a medical device, the payment for the device is packaged into the payment for the associated procedure.

Effective January 1, 2016, in the OPPS and ASC payment systems, payment for the device described by HCPCS code C1841 is packaged into payment for CPT® 0100T. Due to current ASC systems limitations, CMS cannot implement the identical policy in ASCs. As an administrative workaround to the field limit on ASC payments equal to or greater than $100,000, CMS is creating a second device code; HCPCS code C1842, and splitting payments in half across C1841 and C1842. Therefore, effective January 1, 2017, HCPCS code C1842 (Long descriptor -Retinal prosthesis, includes all

See **ASC**, next page

# ASC

previous page

internal and external components; add on to C1841; short descriptor - Retinal prosth, add-on) must be reported with both C1841 and 0100T when a retinal prosthesis is implanted in the ASC (see Table 1).

Since CMS's device payment will be equally split between C1841 and C1842. ASCs must split the submitted device charges equally between C1841 and C1842, to ensure that Medicare pays what they intended to pay. Likewise, when appropriate, the use of the FB modifier (Item provided without cost to provider, supplier or practitioner (examples, but not limited to: covered under warranty, replaced due to defect, free samples)) and FC modifier (Partial credit received for replaced device) would apply to both C1841 and C1842.

**Table 1 − Argus retinal prosthesis add-on code (C1842)**

| 2017 code | 2017 long descriptor | 2017 short descriptor | ASC PI |
|---|---|---|---|
| C1842 | Retinal prosthesis, includes all internal and external components; add on to C1841 | Retinal prosth, add-on | J7 |

## 3. Drugs, biologicals, and radiopharmaceuticals

### a. New 2017 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For 2017, several new HCPCS codes have been created for reporting drugs and biologicals in the ASC payment system, where there have not previously been specific codes available. These new codes are listed in Table 2.

**Table 2**

**New 2017 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals**

| 2017 code | 2017 long descriptor | 2017 short descriptor | ASC PI |
|---|---|---|---|
| A9587 | Gallium ga-68, dotatate, diagnostic, 0.1 millicurie | Gallium ga-68 | K2 |
| A9588 | Fluciciovine f-18, diagnostic, 1 millicurie | Fluciclovine f-18 | K2 |
| C9140 | Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U. | Afstyla factor viii recomb | K2 |
| J0570 | Buprenorphine implant, 74.2 mg | Buprenorphine implant 74.2mg | K2 |
| J7175 | Injection, factor x, (human), 1 i.u. | Inj, factor x, (human), 1iu | K2 |
| J7179 | Injection, von willebrand factor (recombinant), (Vonvendi), 1 i.u. vwf:rco | Vonvendi inj 1 iu vwf:rco | K2 |
| J9034 | Injection, bendamustine hcl (Bendeka), 1 mg | Inj., bendeka 1 mg | K2 |

### b. Other changes to 2017 HCPCS and CPT® codes for certain drugs, biologicals, and radiopharmaceuticals

Many HCPCS and CPT® codes for drugs, biologicals, and radiopharmaceuticals have changes in its HCPCS and CPT® code descriptors that will be effective in 2017. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2016, and replaced with permanent HCPCS codes in 2017. ASCs should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the 2017 HCPCS and CPT® codes.

Table 3 notes those drugs, biologicals, and radiopharmaceuticals that have changes in their HCPCS/CPT® code, its long descriptor, or both. Each product's 2016 HCPCS/CPT® code and long descriptor are noted in the two left hand columns and the 2017 HCPCS/CPT® code and long descriptor are noted in the adjacent right hand columns.

**Table 3**

**Other 2017 HCPCS changes for certain drugs, biologicals, and radiopharmaceuticals**

| 2016 code | 2016 long descriptor | 2017 code | 2017 long descriptor |
|---|---|---|---|
| C9461 | Choline C 11, diagnostic, per study dose | A9515 | Choline c-11, diagnostic, per study dose up to 20 millicuries |
| C9121 | Injection, argatroban, per 5 mg | J0883 | Injection, argatroban, 1 mg (for non-esrd use) |
| C9137 | Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U. | J7207 | Injection, factor viii, (antihemophilic factor, recombinant), pegylated, 1 i.u |
| C9138 | Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U. | J7209 | Injection, factor viii, (antihemophilic factor, recombinant), (nuwiq), 1 i.u. |

See **ASC**, next page

# ASC

previous page

| 2016 code | 2016 long descriptor | 2017 code | 2017 long descriptor |
|---|---|---|---|
| C9139 | Injection, factor ix, albumin fusion protein (recombinant), idelvion, 1 i.u. | J7202 | Injection, factor ix, albumin fusion protein, (recombinant), idelvion, 1 i.u. |
| C9349 | Puraply, and puraply antimicrobial, any type, per square centimeter | Q4172 | Puraply or puraply am, per square centimeter |
| C9470 | Injection, aripiprazole lauroxil, 1 mg | J1942 | Injection, aripiprazole lauroxil, 1 mg |
| C9471 | Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg | J7322 | Hyaluronan or derivative, hymovis, for intra-articular injection, 1 mg |
| C9472 | Injection, talimogene laherparepvec, 1 million plaque forming units (PFU) | J9325 | Injection, talimogene laherparepvec, per 1 million plaque forming units |
| C9473 | Injection, mepolizumab, 1 mg | J2182 | Injection, mepolizumab, 1 mg |
| C9474 | Injection, irinotecan liposome, 1 mg | J9205 | Injection, irinotecan liposome, 1 mg |
| C9475 | Injection, necitumumab, 1 mg | J9295 | Injection, necitumumab, 1 mg |
| C9476 | Injection, daratumumab, 10 mg | J9145 | Injection, daratumumab, 10 mg |
| C9477 | Injection, elotuzumab, 1 mg | J9176 | Injection, elotuzumab, 1 mg |
| C9478 | Injection, sebelipase alfa, 1 mg | J2840 | Injection, sebelipase alfa, 1 mg |
| C9479 | Instillation, ciprofloxacin otic suspension, 6 mg | J7342 | Installation, ciprofloxacin otic suspension, 6 mg |
| C9480 | Injection, trabectedin, 0.1 mg | J9352 | Injection, trabectedin, 0.1 mg |
| C9481 | Injection, reslizumab, 1 mg | J2786 | Injection, reslizumab, 1 mg |
| J3357 | Injection, ustekinumab, 1 mg | J3357 | Ustekinumab, for subcutaneous injection, 1 mg |
| J1745 | Injection, infliximab, 10 mg | J1745 | Injection, infliximab, excludes biosimilar, 10 mg |
| J7201 | Injection, factor ix, fc fusion protein (recombinant), per iu | J7201 | Injection, factor ix, fc fusion protein (recombinant), Alprolix, per iu |
| J7340 | Carbidopa 5 mg/levodopa 20 mg enteral suspension | J7340 | Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml |
| Q9981 | Rolapitant, oral, 1 mg | J8670 | Rolapitant, oral, 1 mg |
| Q4105 | Integra dermal regeneration template (drt), per square centimeter | Q4105 | Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter |

**c. Drugs and biologicals with payments based on average sales price (ASP) effective January 1, 2017**

For 2017, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals continues to be made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, in 2017, a single payment of ASP + 6 percent continues to be made for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2017, payment rates for many drugs and biologicals have changed from the values published in the 2017 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of 2016. In cases where adjustments to payment rates are necessary, CMS is not publishing the updated payment rates in this CR. However, all ASC payable drugs and biologicals effective January 1, 2017, including those that were updated as a result of the new ASP calculations, can be found in the January 2017 ASC Addendum BB at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

See **ASC**, next page

# ASC

previous page

**d. Drugs and biologicals based on ASP methodology with restated payment rates**

Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at *https://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html*.

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request their MAC to adjust the previously processed claims.

**e. Biosimilar biological product payment policy**

Effective January 1, 2017, the payment rate for biosimilars, approved for payment in the ASC payment system, will be the same as the payment rate in the OPPS and physician office setting; calculated as the average sales price (ASP) of the biosimilar(s) described by the HCPCS code + 6 percent of the ASP of the reference product. Payment will be made at the single ASP + 6 percent rate.

You should remember that ASC claims for separately paid biosimilar biological products are required to include a modifier (see Table 4 on page XX) that identifies the specific product's manufacturer. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers.

**f. Billing and payment for new drugs, biologicals, or radiopharmaceuticals approved by the FDA but before assignment of a product-specific HCPCS code**

As in the OPPS, ASCs are allowed to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals that are approved by the Food and Drug Administration (FDA) on or after January 1, 2004, for which OPPS pass-through status has not been approved and a C-code and APC payment have not been assigned using the "unclassified" drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs, biologicals, and therapeutic radiopharmaceuticals that are assigned to HCPCS code C9399 are MAC-priced.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under both the OPPS and ASC payment system unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, are packaged in the ASC setting with payment already included in the surgical procedure performed, and are not billed.

**g. Skin substitute procedure edits**

The payment for skin substitute products that do not qualify for hospital OPPS pass-through status are packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system.

The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 5 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). High cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by CPT® codes 15271-15278. Low cost skin substitute products should only be used in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278. All OPPS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT® codes 15271-15278.

**Table 5 Skin substitute product assignment to high cost/low cost status for 2016**

| 2017 HCPCS code | 2017 short descriptor | 2017 SI | Low/high cost skin substitute |
|---|---|---|---|
| C9363 | Integra Meshed Bil Wound Mat | N1 | High |
| Q4100 | Skin Substitute, NOS | N1 | Low |
| Q4101 | Apligraf | N1 | High |
| Q4102 | Oasis Wound Matrix | N1 | Low |
| Q4103 | Oasis Burn Matrix | N1 | High |
| Q4104 | Integra BMWD | N1 | High |
| Q4105 | Integra DRT | N1 | High |
| Q4106 | Dermagraft | N1 | High |
| Q4107 | GraftJacket | N1 | High |
| Q4108 | Integra Matrix | N1 | High |
| Q4110 | Primatrix | N1 | High |
| Q4111 | Gammagraft | N1 | Low |
| Q4115 | Alloskin | N1 | Low |
| Q4116 | Alloderm | N1 | High |
| Q4117 | Hyalomatrix | N1 | Low |
| Q4121 | Theraskin | N1 | High |
| Q4122 | Dermacell | N1 | High |
| Q4123 | Alloskin | N1 | High |
| Q4124 | Oasis Tri-layer Wound Matrix | N1 | Low |
| Q4126 | Memoderm/derma/ tranz/integup | N1 | High |
| Q4127 | Talymed | N1 | High |
| Q4128 | Flexhd/ Allopatchhd/ Matrixhd | N1 | High |
| Q4131 | Epifix | N1 | High |

See **ASC**, next page

## ASC

previous page

| 2017 HCPCS code | 2017 short descriptor | 2017 SI | Low/high cost skin substitute |
|---|---|---|---|
| Q4132 | Grafix Core | N1 | High |
| Q4133 | Grafix Prime | N1 | High |
| Q4134 | hMatrix | N1 | Low |
| Q4135 | Mediskin | N1 | Low |
| Q4136 | Ezderm | N1 | Low |
| Q4137 | Amnioexcel or Biodexcel, 1cm | N1 | High |
| Q4138 | Biodfence DryFlex, 1cm | N1 | High |
| Q4140 | Biodfence 1cm | N1 | High |
| Q4141 | Alloskin ac, 1cm | N1 | High |
| Q4143* | Repriza, 1cm | N1 | High |
| Q4146* | Tensix, 1cm | N1 | High |
| Q4147 | Architect ecm, 1cm | N1 | High |
| Q4148 | Neox 1k, 1cm | N1 | High |
| Q4150 | Allowrap DS or Dry 1 sq cm | N1 | High |
| Q4151 | AmnioBand, Guardian 1 sq cm | N1 | High |
| Q4152 | Dermapure 1 square cm | N1 | High |
| Q4153 | Dermavest 1 square cm | N1 | High |
| Q4154 | Biovance 1 square cm | N1 | High |
| Q4156 | Neox 100 1 square cm | N1 | High |
| Q4157* | Revitalon 1 square cm | N1 | High |
| Q4158* | MariGen 1 square cm | N1 | High |
| Q4159 | Affinity 1 square cm | N1 | High |
| Q4160 | NuShield 1 square cm | N1 | High |
| Q4161 | Bio-Connekt per square cm | N1 | Low |
| Q4162 | Amnio bio and woundex flow | N1 | Low |
| Q4163* | Amnion bio and woundex sq cm | N1 | High |
| Q4164 | Helicoll, per square cm | N1 | High |
| Q4165 | Keramatrix, per square cm | N1 | Low |
| Q4166* | Cytal, per square cm | N1 | Low |
| Q4167* | Truskin, per square cm | N1 | Low |
| Q4168* | Amnioband, 1 mg | N1 | Low |
| Q4169* | Artacent wound, per square cm | N1 | Low |
| Q4170* | Cygnus, per square cm | N1 | Low |
| Q4171* | Interfyl, 1 mg | N1 | Low |
| Q4172 | PuraPly, PuraPly antimic | K2 | High |
| Q4173* | Palingen or palingen xplus, per sq cm | N1 | Low |
| Q4175* | Miroderm, per square cm | N1 | Low |

*HCPCS codes Q4166, Q4167, Q4168, Q4169, Q4170, Q4171, Q4173, and Q4175 were assigned to the low cost group in the 2017 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4143, Q4146, Q4157, Q4158, and Q4163 are assigned to the high cost group for 2017.

**h. Reassignment of skin substitute products from the low cost group to the high cost group – retroactive change**

One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The start date on this change is retroactive to October 1, 2016. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). The product is listed in Table 6 below.

**Table 6 Updated skin substitute product assignment to high cost status retroactive to October 1, 2016**

| HCPCS code | Short descriptor | ASC PI | Low/high cost status |
|---|---|---|---|
| Q4158 | MariGen 1 square cm | N1 | High |

### 4. Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare administrative contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

See **ASC**, next page

# ASC

previous page

### 5. 2017 wage index

In the 2017 OPPS/ASC final rule with comment period, we informed readers that generally, the Office of Management and Budget (OMB) issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On July 15, 2015, OMB issued OMB bulletin No. 15–01, which provides updates to and supersedes OMB bulletin No. 13–01 that was issued February 28, 2013. The attachment to OMB bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB bulletin No. 15–01 are based on the application of the 2010 standards for delineating metropolitan and micropolitan statistical areas to census bureau population estimates for July 1, 2012, and July 1, 2013. Please refer to page 79562 of the final rule for more details. OMB bulletin No. 15–01 made the following changes that are relevant to the ASC wage index:

- Garfield County, OK, with principal city Enid, OK, which was a Micropolitan (geographically rural) area, now qualifies as an urban new core-based statistical area (CBSA) 21420 called Enid, OK.
- The county of Bedford City, VA, a component of the Lynchburg, VA CBSA 31340, changed to town status and is added to Bedford County. Therefore, the county of Bedford City (SSA state county code 49088, FIPS state county code 51515) is now part of the county of Bedford, VA (SSA state county code 49090, FIPS state county code 51019). However, the CBSA remains Lynchburg, VA, 31340.
- The name of Macon, GA, CBSA 31420, as well as a principal city of the Macon-Warner Robins, GA combined statistical area, is now Macon-Bibb County, GA. The CBSA code remains as 31420.

These changes are effective January 1, 2017. For 2017, the final 2017 ASC wage indexes fully reflect the new OMB labor market area delineations. The final 2017 ASC wage indices are included in Attachment B of CR 9923.

## Additional information

The official instruction, CR 9923, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3683CP.pdf*.

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

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Related Change Request (CR) #: CR 9923
Related CR Release Date: December 22, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3683CP
Implementation Date: January 3, 2017



**Table 4**

**Biosimilar biological product payment and required modifiers**

| HCPCS code | Short descriptor | Long descriptor | ASC PI | FDA approval date | Modifier | Modifier effective date |
|---|---|---|---|---|---|---|
| Q5101 | Inj filgrastim g-csf biosim | Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram | K2 | 3/6/15 | ZA-Novartis/ Sandoz | 1/1/16 |
| Q5102 | Inj., infliximab biosimilar | Injection, Infliximab, Biosimilar, 10 mg | K2 | 4/5/16 | ZB-Pfizer/ Hospira | 4/5/16 |

Consolidated Billing

# Annual update of HCPCS codes used for home health consolidated billing enforcement

***Note**: This article was revised January 12, 2017, to correct table in the Background section. The table incorrectly listed code 97177. The correct code is 97167 (OT EVAL HIGH COMPLEX 60 MIN). All other information is unchanged. This information was previously published in the December 2016 Medicare B Connection, page 39.*

## Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs) and other providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

## Provider action needed

Change request (CR) 9771 provides the 2017 annual update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. Make sure that your billing staffs are aware of these changes.

## Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS).

With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, K codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency.

The HCPCS codes in the table below are being added to the HH consolidated billing therapy code list, effective for services on or after January 1, 2017. These codes replace HCPCS codes: 97001, 97002, 97003, 97004.

| HCPCS code | Descriptor |
|---|---|
| 97161 | PT EVAL LOW COMPLEX 20 MIN |
| 97162 | PT EVAL MOD COMPLEX 30 MIN |
| 97163 | PT EVAL HIGH COMPLEX 45 MIN |
| 97164 | PT RE-EVAL EST PLAN CARE |
| 97165 | OT EVAL LOW COMPLEX 30 MIN |
| 97166 | OT EVAL MOD COMPLEX 45 MIN |
| 97167 | OT EVAL HIGH COMPLEX 60 MIN |
| 97168 | OT RE-EVAL EST PLAN CARE |

G0279 and G0280 are deleted from the HH consolidated billing therapy code list. These codes were replaced with 0019T and should have been removed from the list in earlier updates. Effective January 1, 2015, these codes were redefined for another purpose. MACs will adjust claims denied due to HH consolidated billing with HCPCS codes G0279 and G0280 and line item dates of service on or after January 1, 2015, if brought to their attention.

## Additional information

The official instruction, CR 9771, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3618CP.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 |
|---|---|
| 1/12/17 | This article was revised to correct in the table. The table incorrectly listed HCPCS code 97177. The correct HCPCS code is HCPCS 97167 (OT EVAL HIGH COMPLEX 60 MIN). |
| 11/17/16 | Initial article released |

*MLN Matters*® Number: MM9771
Related Change Request (CR) #: CR 9771
Related CR Release Date: October 7, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3618CP
Implementation Date: January 3, 2017

Drugs & Biologicals

# April 2017 ASP drug pricing files and revision to prior files

## 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) 9945 provides the April 2017 quarterly update and instructs MACs to download and implement the April 2017 average sales price (ASP) drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised January 2017, October 2016, July 2016, and April 2016 ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 3, 2017, with dates of service April 1, 2017, through June 30, 2017. MACs will not search and adjust claims previously processed unless brought to their attention.

For claims with a date of service on or after January 1, 2017, and consistent with Section 5004 of the 21st Century Cures Act, which was signed into law on December 13, 2016, payment for infusion drugs furnished through a covered item of durable medical equipment (DME) will be based on Section 1847A of the Social Security Act, meaning that most of the payments will be based on the ASP of these drugs. Payment for DME infusion drugs that do not appear on the ASP drug pricing files will be determined by the MACs in accordance with the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*.

Make sure your billing staffs are aware of these changes.

## Background

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

The following table shows how the quarterly payment files will be applied:

| Files | Effective dates of service |
|---|---|
| April 2017 ASP and ASP NOC | April 1, 2017, through June 30, 2017 |
| January 2017 ASP and ASP NOC | January 1, 2017, through March 31, 2017 |
| October 2016 ASP and ASP NOC | October 1, 2016, through December 31, 2016 |
| July 2016 ASP and ASP NOC | July 1, 2016, through September 30, 2016 |
| April 2016 ASP and ASP NOC | April 1, 2016, through June 30, 2016 |

## Additional information

The official instruction, CR 9945, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3692CP.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/*.

*MLN Matters*® Number: MM9945
Related Change Request (CR) #: CR 9945
Related CR Release Date: January 13, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3692CP
Implementation Date: April 3, 2017

Durable Medical Equipment

# 2017 DMEPOS HCPCS jurisdiction list

## Provider types affected

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

## What you need to know

Change request (CR) 9903 notifies suppliers that the spreadsheet containing the jurisdiction list of Healthcare Common Procedure Coding System (HCPCS) codes is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the *Medicare Claims Processing Manual* are reflected in the recurring update notification. The document for the 2017 DMEPOS jurisdiction list is an Excel® spreadsheet and is available at *https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html* and is also attached CR 9903.

## Additional information

The official instruction, CR 9903, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3689CP.pdf*. If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

## Document history

- **January 6, 2017**: Article revised to reflect revised CR 9903. In the article, the CR release date, transmittal number and the web address for accessing the CR are revised. All other information remains the same.
- **December 26, 2016**: Initial issuance

*MLN Matters*® Number: MM9903
Related CR #: CR 9903
Related CR Release Date: January 5, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3689CP
Implementation Date: January 24, 2017



# Quarterly provider update

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

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

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

# 2017 DMEPOS jurisdiction listing

This article is informational and is based on change request (CR) 9903 that notifies providers that the spreadsheet containing an updated list of the healthcare common procedure coding system (HCPCS) codes for durable medical equipment Medicare administrative contractor (DME MAC) or Part B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year.

The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2017 jurisdiction list is attached to CR 9903 at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3689CP.pdf*. Note that deleted codes are valid for dates of service on or before the date of deletion and updated codes are in bold. The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.

**Note**: Deleted codes are valid for dates of service on or before the date of deletion.

**Note**: Updated codes are in **bold**.

**Note**: The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.

**Note**: **All "local carrier" language has been changed to "Part B MAC".**

| HCPCS | Description | Jurisdiction |
|---|---|---|
| A0021 - A0999 | Ambulance services | Part B MAC |
| A4206 - A4209 | Medical, surgical, and self - administered injection supplies | Part B MAC if incident to a physician's service (not separately payable). If other, supplies DME MAC. |
| A4210 | Needle free injection device | DME MAC |
| A4211 | Medical, surgical, and self - administered injection supplies | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4212 | Non - coring needle or stylet with or without catheter | Part B MAC |
| A4213 - A4215 | Medical , surgical, and self - administered injection supplies | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4216 - A4218 | Saline | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4220 | Refill kit for implantable pump | Part B MAC |
| A4221 - A4236 | Self - administered injection and diabetic supplies | DME MAC |
| A4244 - A4250 | Medical, surgical, and self - administered injection supplies | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4252 - A4259 | Diabetic supplies | DME MAC |
| A4261 | Cervical cap for contraceptive use | Part B MAC |
| A4262 - A4263 | Lacrimal duct implants | Part B MAC |
| A4264 | Contraceptive implant | Part B MAC |
| A4265 | Paraffin | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4266 - A4269 | Contraceptives | Part B MAC |
| A4270 | Endoscope sheath | Part B MAC |
| A4280 | Accessory for breast prosthesis | DME MAC |
| A4281 - A4286 | Accessory for breast pump | DME MAC |
| A4290 | Sacral nerve stimulation test lead | Part B MAC |
| A4300 - A4301 | Implantable catheter | Part B MAC |
| A4305 - A4306 | Disposable drug delivery system | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |

See **DMEPOS**, next page

# DMEPOS

previous page

| HCPCS | Description | Jurisdiction |
|---|---|---|
| A4310 - A4358 | Incontinence supplies/urinary supplies | If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC. |
| A4360 - A4435 | Urinary supplies | If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC. |
| A4450 - A4456 | Tape; Adhesive remover | Part B MAC if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device. If other, DME MAC. |
| A4458 - A4459 | Enema bag/ system | DME MAC |
| A4461 - A4463 | Surgical dressing holders | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4465 - A4467 | Non - elastic binder and garment, strap, covering | DME MAC |
| A4470 | Gravlee jet washer | Part B MAC |
| A4480 | Vabra aspirator | Part B MAC |
| A4481 | Tracheostomy supply | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4483 | Moisture exchanger | DME MAC |
| A4490 - A4510 | Surgical stockings | DME MAC |
| A4520 | Diapers | DME MAC |
| A4550 | Surgical trays | Part B MAC |

| HCPCS | Description | Jurisdiction |
|---|---|---|
| A4553 - A4554 | Underpads | DME MAC |
| A4555 - A4558 | Electrodes; lead wires; conductive paste | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4559 | Coupling gel | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4561 - A4562 | Pessary | Part B MAC |
| A4565 - A4566 | Sling | Part B MAC |
| A4570 | Splint | Part B MAC |
| A4575 | Topical hyperbaric oxygen chamber, disposable | DME MAC |
| A4595 | TENS supplies | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4600 | Sleeve for intermittent limb compression device | DME MAC |
| A4601 - A4602 | Lithium replacement batteries | DME MAC |
| A4604 | Tubing for positive airway pressure device | DME MAC |
| A4605 | Tracheal suction catheter | DME MAC |
| A4606 | Oxygen probe for oximeter | DME MAC |
| A4608 | Transtracheal oxygen catheter | DME MAC |

See **DMEPOS**, next page

# DMEPOS

previous page

| HCPCS | Description | Jurisdiction |
|---|---|---|
| A4611 - A4613 | Oxygen equipment batteries and supplies | DME MAC |
| A4614 | Peak flow rate meter | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4615 - A4629 | Oxygen & tracheostomy supplies | Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC. |
| A4630 - A4640 | DME supplies | DME MAC |
| A4641 - A4642 | Imaging agent; contrast material | Part B MAC |
| A4648 | Tissue marker, implanted | Part B MAC |
| A4649 | Miscellaneous surgical supplies | Part B MAC if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC. |
| A4650 | Implantable radiation dosimeter | Part B MAC |
| A4651 - A4932 | Supplies for ESRD | DME MAC (not separately payable) |
| A5051 - A5093 | Additional ostomy supplies | If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC. |
| A5102 - A5200 | Additional incontinence and ostomy supplies | If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC. |
| A5500 - A5513 | Therapeutic shoes | DME MAC |
| A6000 | Non - contact wound warming cover | DME MAC |
| A6010 - A6024 | Surgical dressing | Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC. |
| A6025 | Silicone gel sheet | Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC. |
| A6154 - A6411 | Surgical dressing | Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC. |
| A6412 | Eye patch | Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC. |
| A6413 | Adhesive bandage | Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC. |
| A6441 - A6512 | Surgical dressings | Part B MAC if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC. |
| A6513 | Compression burn mask | DME MAC |
| A6530 - A6549 | Compression gradient stockings | DME MAC |
| A6550 | Supplies for negative pressure wound therapy electrical pump | DME MAC |

See **DMEPOS**, next page

# DMEPOS

previous page

| HCPCS | Description | Jurisdiction |
|---|---|---|
| A7000 - A7002 | Accessories for suction pumps | DME MAC |
| A7003 - A7039 | Accessories for nebulizers, aspirators, and ventilators | DME MAC |
| A7040 - A7041 | Chest drainage supplies | Part B MAC |
| A7044 - A7047 | Respiratory accessories | DME MAC |
| A7048 | Vacuum drainage supply | Part B MAC |
| A7501 - A7527 | Tracheostomy supplies | DME MAC |
| A8000 - A8004 | Protective helmets | DME MAC |
| A9150 | Non - prescription drugs | Part B MAC |
| A9152 - A9153 | Vitamins | Part B MAC |
| A9155 | Artificial saliva | Part B MAC |
| A9180 | Lice infestation treatment | Part B MAC |
| A9270 | Noncovered items or services | DME MAC |
| A9272 | Disposable wound suction pump | DME MAC |
| A9273 | Hot water bottles, ice caps or collars, and heat and/or cold wraps | DME MAC |
| A9274 - A9278 | Glucose monitoring | DME MAC |
| A9279 | Monitoring feature/device | DME MAC |
| A9280 | Alarm device | DME MAC |
| A9281 | Reaching/ grabbing device | DME MAC |
| A9282 | Wig | DME MAC |
| A9283 | Foot off - loading device | DME MAC |
| A9284 - A9286 | Non - electric spirometer, inversion devices and hygienic items | DME MAC |
| A9300 | Exercise equipment | DME MAC |

| HCPCS | Description | Jurisdiction |
|---|---|---|
| A9500 - A9700 | Supplies for radiology procedures | Part B MAC |
| A9900 | Miscellaneous DME supply or accessory | Part B MAC if used with implanted DME. If other, DME MAC. |
| A9901 | Delivery | DME MAC |
| A9999 | Miscellaneous DME supply or accessory | Part B MAC if used with implanted DME. If other, DME MAC. |
| B4034 - B9999 | Enteral and parenteral therapy | DME MAC |
| D0120 - D9999 | Dental procedures | Part B MAC |
| E0100 - E0105 | Canes | DME MAC |
| E0110 - E0118 | Crutches | DME MAC |
| E0130 - E0159 | Walkers | DME MAC |
| E0160 - E0175 | Commodes | DME MAC |
| E0181 - E0199 | Decubitus care equipment | DME MAC |
| E0200 - E0239 | Heat/cold applications | DME MAC |
| E0240 - E0248 | Bath and toilet aids | DME MAC |
| E0249 | Pad for heating unit | DME MAC |
| E0250 - E0304 | Hospital beds | DME MAC |
| E0305 - E0326 | Hospital bed accessories | DME MAC |
| E0328 - E0329 | Pediatric hospital beds | DME MAC |
| E0350 - E0352 | Electronic bowel irrigation system | DME MAC |

See **DMEPOS**, next page

# DMEPOS

previous page

| HCPCS | Description | Jurisdiction |
|---|---|---|
| E0370 | Heel pad | DME MAC |
| E0371 - E0373 | Decubitus care equipment | DME MAC |
| E0424 - E0484 | Oxygen and related respiratory equipment | DME MAC |
| E0485 - E0486 | Oral device to reduce airway collapsibility | DME MAC |
| E0487 | Electric spirometer | DME MAC |
| E0500 | IPPB machine | DME MAC |
| E0550 - E0585 | Compressors/ nebulizers | DME MAC |
| E0600 | Suction pump | DME MAC |
| E0601 | CPAP device | DME MAC |
| E0602 - E0604 | Breast pump | DME MAC |
| E0605 | Vaporizer | DME MAC |
| E0606 | Drainage board | DME MAC |
| E0607 | Home blood glucose monitor | DME MAC |
| E0610 - E0615 | Pacemaker monitor | DME MAC |
| E0616 | Implantable cardiac event recorder | Part B MAC |
| E0617 | External defibrillator | DME MAC |
| E0618 - E0619 | Apnea monitor | DME MAC |
| E0620 | Skin piercing device | DME MAC |
| E0621 - E0636 | Patient lifts | DME MAC |
| E0637 - E0642 | Standing devices/lifts | DME MAC |
| E0650 - E0676 | Pneumatic compressor and appliances | DME MAC |
| E0691 - E0694 | Ultraviolet light therapy systems | DME MAC |
| E0700 | Safety equipment | DME MAC |
| E0705 | Transfer board | DME MAC |
| E0710 | Restraints | DME MAC |
| E0720 - E0745 | Electrical nerve stimulators | DME MAC |

| HCPCS | Description | Jurisdiction |
|---|---|---|
| E0746 | EMG device | Part B MAC |
| E0747 - E0748 | Osteogenic stimulators | DME MAC |
| E0749 | Implantable osteogenic stimulators | Part B MAC |
| E0755 - E0770 | Stimulation devices | DME MAC |
| E0776 | IV pole | DME MAC |
| E0779 - E0780 | External infusion pumps | DME MAC |
| E0781 | Ambulatory infusion pump | DME MAC |
| E0782 - E0783 | Infusion pumps, implantable | Part B MAC |
| E0784 | Infusion pumps, insulin | DME MAC |
| E0785 - E0786 | Implantable infusion pump catheter | Part B MAC |
| E0791 | Parenteral infusion pump | DME MAC |
| E0830 | Ambulatory traction device | DME MAC |
| E0840 - E0900 | Traction equipment | DME MAC |
| E0910 - E0930 | Trapeze/ fracture frame | DME MAC |
| E0935 - E0936 | Passive motion exercise device | DME MAC |
| E0940 | Trapeze equipment | DME MAC |
| E0941 | Traction equipment | DME MAC |
| E0942 - E0945 | Orthopedic cevices | DME MAC |
| E0946 - E0948 | Fracture frame | DME MAC |

See **DMEPOS**, next page

# DMEPOS

previous page

| HCPCS | Description | Jurisdiction |
|---|---|---|
| E0950 - E1298 | Wheelchairs | DME MAC |
| E1300 - E1310 | Whirlpool equipment | DME MAC |
| E1352 - E1392 | Additional oxygen related equipment | DME MAC |
| E1399 | Miscellaneous DME | Part B MAC if implanted DME. If other, DME MAC. |
| E1405 - E1406 | Additional oxygen equipment | DME MAC |
| E1500 - E1699 | Artificial kidney machines and accessories | DME MAC (not separately payable) |
| E1700 - E1702 | TMJ device and supplies | DME MAC |
| E1800 - E1841 | Dynamic flexion devices | DME MAC |
| E1902 | Communication board | DME MAC |
| E2000 | Gastric suction pump | DME MAC |
| E2100 - E2101 | Blood glucose monitors with special features | DME MAC |
| E2120 | Pulse generator for tympanic treatment of inner ear | DME MAC |
| E2201 - E2397 | Wheelchair accessories | DME MAC |
| E2402 | Negative pressure wound therapy pump | DME MAC |
| E2500 - E2599 | Speech generating device | DME MAC |
| E2601 - E2633 | Wheelchair cushions and accessories | DME MAC |
| E8000 - E8002 | Gait trainers | DME MAC |
| G0008 - G0329 | Misc. professional services | Part B MAC |
| G0333 | Dispensing fee | DME MAC |
| G0337 - G0365 | Misc. professional services | Part B MAC |
| G0372 | Misc. professional services | Part B MAC |
| G0378 - **G0490**, **G0493** - G9**862** | Misc. professional services | Part B MAC |
| J0120 - J3570 | Injection | Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC. |
| J3590 | Unclassified biologicals | Part B MAC |
| J7030 - J7131 | Miscellaneous drugs and solutions | Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC. |
| J717**5 - J7179** | **Clotting factors** | Part B MAC |
| J7180 - J7195 | Antihemophilic factor | Part B MAC |
| J7196 - J7197 | Antithrombin III | Part B MAC |
| J7198 | Anti - inhibitor; per I.U. | Part B MAC |
| J7199 - J720**9** | Other hemophilia clotting factors | Part B MAC |
| J7297 - J7307 | Contraceptives | Part B MAC |
| J7308 - J7309 | Aminolevulinic acid HCL | Part B MAC |
| J7310 | Ganciclovir, long - acting implant | Part B MAC |
| J7311 - J7316 | Ophthalmic drugs | Part B MAC |
| J7320 - J7328 | Hyaluronan | Part B MAC |
| J7330 | Autologous cultured chondrocytes, implant | Part B MAC |
| J7336 | Capsaicin | Part B MAC |
| J7340 | Carbidopa/ Levodopa | Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC. |
| **J7342** | **Ciprofloxacin otic** | **Part B MAC** |
| J7500 - J7599 | | Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC. |

See **DMEPOS**, next page

# DMEPOS

previous page

| HCPCS | Description | Jurisdiction |
|---|---|---|
| J7604 - J7699 | Inhalation solutions | Part B MAC if incident to a physician's service. If other, DME MAC. |
| J7799 - J7999 | NOC drugs, other than inhalation drugs | Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC. |
| J8498 | Anti - emetic drug | DME MAC |
| J8499 | Prescription drug, oral, non | Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC. |
| J8501 - J8999 | Oral anti - cancer drugs | DME MAC |
| J9000 - J9999 | Chemotherapy drugs | Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC. |
| K0001 - K0108 | Wheelchairs | DME MAC |
| K0195 | Elevating leg rests | DME MAC |
| K0455 | Infusion pump used for uninterrupted administration of epoprostenal | DME MAC |
| K0462 | Loaner equipment | DME MAC |
| K0552 | External infusion pump supplies | DME MAC |
| K0601 - K0605 | External infusion pump batteries | DME MAC |
| K0606 - K0609 | Defibrillator accessories | DME MAC |
| K0669 | Wheelchair cushion | DME MAC |
| K0672 | Soft interface for orthosis | DME MAC |
| K0730 | Inhalation drug delivery system | DME MAC |
| K0733 | Power wheelchair accessory | DME MAC |
| K0738 | Oxygen equipment | DME MAC |
| K0739 | Repair or Nonroutine Service for DME | Part B MAC if implanted DME. If other, DME MAC |
| K0740 | Repair or nonroutine service for oxygen equipment | DME MAC |
| K0743 - K0746 | Suction pump and dressings | DME MAC |
| K0800 - K0899 | Power mobility devices | DME MAC |
| K0900 | Custom DME, other than wheelchair | DME MAC |
| L0112 - L4631 | Orthotics | DME MAC |
| L5000 - L5999 | Lower limb prosthetics | DME MAC |
| L6000 - L7499 | Upper limb prosthetics | DME MAC |
| L7510 - L7520 | Repair of prosthetic device | Part B MAC if repair of implanted prosthetic device. If other, DME MAC. |
| L7600 | Prosthetic donning sleeve | DME MAC |
| L7900 - L7902 | Vacuum erection system | DME MAC |
| L8000 - L8485 | Prosthetics | DME MAC |
| L8499 | Unlisted Procedure for miscellaneous prosthetic services | Part B MAC if implanted prosthetic device. If other, DME MAC. |
| L8500 - L8501 | Artificial larynx; tracheostomy speaking valve | DME MAC |
| L8505 | Artificial larynx accessory | DME MAC |
| L8507 | Voice prosthesis, patient inserted | DME MAC |
| L8509 | Voice prosthesis, inserted by a licensed health care provider | Part B MAC for dates of service on or after 10/01/2010. DME MAC for dates of service prior to 10/01/2010 |
| L8510 | Voice prosthesis | DME MAC |

See **DMEPOS**, next page

# DMEPOS

previous page

| HCPCS | Description | Jurisdiction |
|---|---|---|
| L8511 - L8515 | Voice prosthesis | Part B MAC if used with tracheoesophageal voice prostheses inserted by a licensed health care provider. If other, DME MAC |
| L8600 - L8699 | Prosthetic implants | Part B MAC |
| L9900 | Miscellaneous orthotic or prosthetic component or accessory | Part B MAC if used with implanted prosthetic device. If other, DME MAC. |
| M0075 - M0301 | Medical services | Part B MAC |
| P2028 - P9615 | Laboratory tests | Part B MAC |
| Q0035 | Influenza vaccine; | Part B MAC |
| Q0081 | Infusion therapy | Part B MAC |
| Q0083 - Q0085 | Chemotherapy administration | Part B MAC |
| Q0091 | Smear preparation | Part B MAC |
| Q0092 | Portable X - ray setup | Part B MAC |
| Q0111 - Q0115 | Miscellaneous lab services | Part B MAC |
| Q0138 - Q0139 | Ferumoxytol injection | Part B MAC |
| Q0144 | Azithromycin dihydrate | Part B MAC if incident to a physician's service. If other, DME MAC. |
| Q0161 - Q0181 | Anti - emetic | DME MAC |
| Q0478 - Q0509 | Ventricular assist devices | Part B MAC |
| Q0510 - Q0514 | Drug dispensing fees | DME MAC |
| Q0515 | Sermorelin acetate | Part B MAC |
| Q1004 - Q1005 | New technology IOL | Part B MAC |
| Q2004 | Irrigation solution | Part B MAC |
| Q2009 | Fosphenytoin | Part B MAC |
| Q2017 | Teniposide | Part B MAC |
| Q2026 - Q2028 | Injectable dermal fillers | Part B MAC |
| Q2034 - Q2039 | Influenza vaccine | Part B MAC |
| Q2043 | Sipuleucel - T | Part B MAC |
| Q2049 - Q2050 | Doxorubicin | Part B MAC if incident to a physician's service orused in an implanted infusion pump. If other, DME MAC. |
| **Q2052** | **IVIG demonstration** | **DME MAC** |
| Q3001 | Supplies for radiology procedures | Part B MAC |
| Q3014 | Telehealth originating site facility fee | Part B MAC |
| Q3027 - Q3028 | Vaccines | Part B MAC |
| Q3031 | Collagen skin test | Part B MAC |
| Q4001 - Q4051 | Splints and casts | Part B MAC |
| Q4074 | Inhalation drug | Part B MAC if incident to a physician's service. If other, DME MAC. |
| Q4081 | Epoetin | Part B MAC |
| Q4082 | Drug subject to competitive acquisition program | Part B MAC |
| Q4100 - Q41**75** | Skin substitutes | Part B MAC |
| Q5001 - Q5010 | Hospice services | Part B MAC |
| Q5101 - **Q5102** | Injection | Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC. |
| Q9950 - Q9954 | Imaging agents | Part B MAC |
| Q9955 - Q9957 | Microspheres | Part B MAC |
| Q9958 - Q9969 | Imaging agents | Part B MAC |
| **Q9982 - Q9983** | **Supplies for radiology procedures** | **Part B MAC** |
| R0070 - R0076 | Diagnostic radiology services | Part B MAC |
| V2020 - V2025 | Frames | DME MAC |
| V2100 - V2513 | Lenses | DME MAC |
| V2520 - V2523 | Hydrophilic contact lenses | Part B MAC if incident to a physician's service. If other, DME MAC. |

See **DMEPOS**, next page

Laboratory/Pathology

# Changes to the laboratory NCD edit software for April 2017

## 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) 9934 informs MACs about the changes that will be included in the April 2017 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

## Background

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so laboratory claims subject to one of the 23 NCDs (*Medicare National Coverage Determinations Manual*, Sections 190.12-190.34, available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part3.pdf*) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, Section 120.2 of the *Medicare Claims Processing Manual*, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. This manual chapter is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf*. 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. CR 9934 lists numerous changes to the codes applicable to the various laboratory NCDs code lists for April 2017. Those changes are too numerous to repeat in this article, but the changes are detailed in the spreadsheet attachments to CR 9934.

## Additional information

The official instruction, CR 9934, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3691CP.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/*.

*MLN Matters*® Number: MM9934
Related Change Request (CR) #: CR 9934
Related CR Release Date: January 13, 2017
Effective Date: October 1, 2016
Related CR Transmittal #: R3691CP
Implementation Date: April 3, 2017



## DMEPOS

previous page

| HCPCS | Description | Jurisdiction |
|---|---|---|
| V2530 - V2531 | Contact lenses, scleral | DME MAC |
| V2599 | Contact lens, other type | Part B MAC if incident to a physician's service. If other, DME MAC. |
| V2600 - V2615 | Low vision aids | DME MAC |
| V2623 - V2629 | Prosthetic eyes | DME MAC |
| V2630 - V2632 | Intraocular lenses | Part B MAC |
| V2700 - V2780 | Miscellaneous vision service | DME MAC |
| V2781 | Progressive lens | DME MAC |
| V2782 - V2784 | Lenses | DME MAC |
| V2785 | Processing - - corneal tissue | Part B MAC |
| V2786 | Lens | DME MAC |
| V2787 - V2788 | Intraocular lenses | Part B MAC |
| V2790 | Amniotic membrane | Part B MAC |
| V2797 | Vision supply | DME MAC |
| V2799 | Miscellaneous vision service | DME MAC |
| V5008 - V5299 | Hearing services | Part B MAC |
| V5336 | Repair/ modification of augmentative communicative system or device | DME MAC |
| V5362 - V5364 | Speech screening | Part B MAC |

# 2017 annual update for annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

## Provider types affected

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

## Provider action needed

Change request (CR) 9909 provides instructions for the 2017 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. This update applies to Chapter 16, Section 20 of the *Medicare Claims Processing Manual*.

## Background

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), the annual update to the local clinical laboratory fees for 2017 is 0.70 percent. The annual update to payments made on a reasonable charge basis for all other laboratory services for 2017 is 1.00 percent (See 42 CFR 405.509(b)(1)).

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA). The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

## Key points of CR 9909

### National minimum payment amounts

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge.

The 2017 national minimum payment amount is $14.49 ($14.39 times 0.70 percent update for 2017). The affected codes for the national minimum payment amount are CPT® 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, G0476, and P3000.

### National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

### Access to data file

Internet access to the 2017 clinical laboratory fee schedule data file will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Other interested parties, such as the Medicaid state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, should use the internet to retrieve the 2017 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

### Data file format

For each test code, if your system retains only the pricing amount, load the data from the field named “60% Pricing Amt.” For each test code, if your system has been developed to retain the local fee and the NLA, you may load the data from the fields named “60% Local Fee Amt” and “60% Natl Limit Amt” to determine payment. For test codes for cervical or vaginal smears (pap smears), you should load the data from the field named “60% Pricing Amt” which reflects the lower of the local fee or the NLA, but not less than the national minimum payment amount. MACs should use the field “62% Pricing Amt” for payment to qualified laboratories of sole community hospitals.

## Public comments and final payment determinations

On July 18, 2016, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input on payment methods for reconsidered 2016 codes and new 2017 codes. Notice of the meeting was published in the *Federal Register* May 13, 2016 and on the CMS website on approximately May 18, 2016. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*.

Additional written comments from the public were accepted until October 31, 2016. CMS has posted a summary of the public comments and the rationale for the final payment determinations at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2017-CLFS-Codes-Final-Determinations.pdf*.

### Pricing information

The 2017 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing

See **CLFS**, next page

# CLFS

previous page

home or homebound patient. If there is a revision to the standard mileage rate for 2017, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2017 clinical laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the clinical laboratory improvement amendments (CLIA).

### Organ or disease-oriented panel codes

Similar to prior years, the 2017 pricing amounts for certain organ or disease-panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

### Mapping information

**New codes**

G0659 is priced at the same rate as code G0479.

80305 is priced at the same rate as code G0477.

80306 is priced at the same rate as code G0478.

80307 is priced at the same rate as code G0479.

81327 is priced at the same rate as CPT® 81287.

81413 is priced at the same rate as CPT® 81435.

81414 is priced at the same rate as CPT® 81436.

81422 is priced at the same rate as CPT® 81436.

81439 is priced at the same rate as CPT® 81435.

81539 is priced at the same rate as CPT® 0010M

84410 is priced at the same rate as the sum of CPT® 84402 and 84403

87483 is priced at the same rate as CPT® 87633.

87338QW is priced at the same rate as CPT® 87338.

87631QW is priced at the same rate as CPT® 87631.

**Existing codes:**

81420 is priced at the same rate as CPT® 81435.

G0475 is priced at the same rate as CPT® 87389.

G0476 is priced at the same rate as CPT® 87624.

G0480 is priced at the same rate as 4.75 times CPT® 82542.

G0481 is priced at the same rate as 6.50 times CPT® 82542.

G0482 is priced at the same rate as 8.25 times CPT® 82542.

G0483 is priced at the same rate as 10.25 times CPT® 82542.

G0477, G0478, G0479, 0010M, and 82272QW are all to be deleted.

### Laboratory costs subject to reasonable charge payment in 2017

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for 2017 is 1.0 percent.

*Chapter 23, Sections 80 through 80.8* of the *Medicare Claims Processing Manual* contains instructions for determining the reasonable charge payment. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the HCPCS in the following list are performed for independent dialysis facility patients, Chapter 8, Section 60.3 of the *Medicare Claims Processing Manual* instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

**Note**: Reasonable charge codes P9070, P9071, P9072 and 89337 may be included in the next calendar year's reasonable charge update.

### Blood products

| | | |
|---|---|---|
| P9010 | P9033 | P9053 |
| P9011 | P9034 | P9054 |
| P9012 | P9035 | P9055 |
| P9016 | P9036 | P9056 |
| P9017 | P9037 | P9057 |
| P9019 | P9038 | P9058 |
| P9020 | P9039 | P9059 |
| P9021 | P9040 | P9060 |
| P9022 | P9044 | P9070 |
| P9023 | P9050 | P9071 |
| P9031 | P9051 | P9072 |
| P9032 | P9052 | |

Also, payment for the following codes should be applied to the blood deductible as instructed in Chapter 3, Sections 20.5 through 20.5.4 of the *Medicare General Information, Eligibility and Entitlement Manual*.

| | | | |
|---|---|---|---|
| P9010 | P9022 | P9040 | P9056 |
| P9016 | P9038 | P9051 | P9057 |
| P9021 | P9039 | P9054 | P9058 |

See **CLFS**, next page

## CLFS

previous page

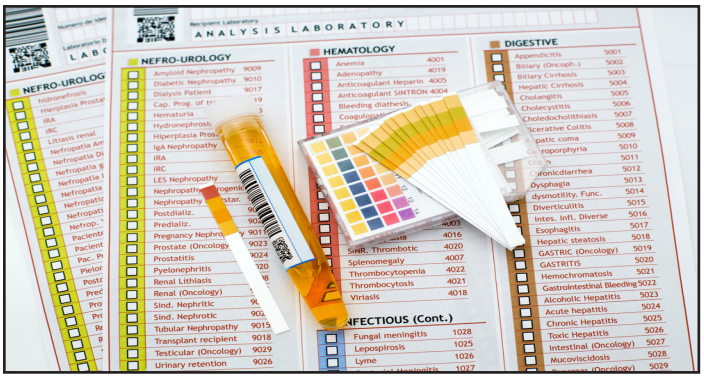
**Note**: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047, should be obtained from the Medicare Part B drug pricing files.

### Transfusion medicine

| | | | |
|---|---|---|---|
| 86850 | 86901 | 86927 | 86970 |
| 86860 | 86902 | 86930 | 86971 |
| 86870 | 86904 | 86931 | 86972 |
| 86880 | 86905 | 86932 | 86975 |
| 86885 | 86906 | 86945 | 86976 |
| 86886 | 86920 | 86950 | 86977 |
| 86890 | 86921 | 86960 | 86978 |
| 86891 | 86922 | 86965 | 86985 |
| 86900 | 86923 | | |

### Reproductive medicine procedures

| | | |
|---|---|---|
| 89250 | 89261 | 89337 |
| 89251 | 89264 | 89342 |
| 89253 | 89268 | 89343 |
| 89254 | 89272 | 89344 |
| 89255 | 89280 | 89346 |
| 89257 | 89281 | 89352 |
| 89258 | 89290 | 89353 |
| 89259 | 89291 | 89354 |
| 89260 | 89335 | 89356 |




### Additional information

The official instruction, CR 9909, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3687CP.pdf*.

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

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Related CR Transmittal #: R3687CP
Implementation Date: January 3, 2017

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# Additional guidance for clinical laboratories as data reporting begins

### Provider types affected

This article is intended for Medicare Part B clinical laboratories that submit claims to Medicare administrative contractors (MACs) for services furnished to Medicare beneficiaries and are required to report private payor rate data to the Centers for Medicare & Medicaid Services (CMS).

### Provider action needed

This article is intended to provide additional guidance to 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 data reporting period for the CLFS opened on January 1, 2017.

To help determine if your laboratory is considered an applicable laboratory, please refer to the guidance in *MLN Matters*® article SE1619, "Medicare Part B Clinical Laboratory Fee Schedule: Guidance to Laboratories for Collecting and Reporting Data for the Private Payor Rate-Based Payment System," which is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1619.pdf*.

### Background

CMS has developed an online data collection system to assist laboratories in submitting data to CMS, which are due by March 31, 2017. A detailed user guide on how to access and use this system is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*.

Laboratories must designate both a CLFS submitter and CLFS certifier in the data collection system. These must be two different individuals. The CLFS submitter must be registered in Medicare's Provider Enrollment, Chain and Ownership System (PECOS) as a user or authorized user on the PECOS Medicare enrollment forms (in other words

See **DATA**, next page

# DATA

previous page

CLFS submitters must have their name appear within one of the following 855 application forms: A,B,C,I,R). The CLFS certifier does not need to be registered in PECOS.

A data reporting template is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*. Laboratories seeking to upload their data to the CLFS data collection system should use this template.

**Tips for smooth data submissions:**

- Please follow the formatting guidelines outlined in the user guide and on the data collection template. The CLFS data collection system will identify formatting errors in your file before you are able to certify the data and submit it. However, for large volumes of data, this process may take several hours to validate. Thus, those files with fewer formatting errors will be processed more efficiently.
- Please use the CLFS applicable information HCPCS codes file available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*. The system will only accept HCPCS codes listed on this file.
- The cleaner the file, the smoother the upload process will be.

**Important information for large laboratories: If your laboratory expects to submit over 100,000 lines of data in the .csv template, please first contact the CMS/CLFS helpdesk at *clfshelpdesk@dcca.com*.

## 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-Service-Payment/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/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

*MLN Matters*® Number: SE17002
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Article Release Date: January 4, 2017
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation N/A



# Guidelines for unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable).

Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks.

Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

> The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

**Source**: CMS Pub. 100-06, Chapter 5, Section 410.10

# CMS names C2C as new qualified independent contractor for Florida, Puerto Rico and USVI

The Centers for Medicare & Medicaid Services (CMS) recently awarded the qualified independent contractor (QIC) Part A East contract to C2C Innovative Solutions, Inc. (C2C). C2C will begin processing new reconsideration requests of initial Medicare claim determinations or redeterminations for Part A Medicare and Medicare Part B of A claim appeals February 14, 2017.

C2C will also be responsible for conducting expedited reconsiderations on service termination and hospital discharge reviews performed by the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations' (QIOs). C2C currently serves as the QIC responsible for processing new reconsideration requests of initial Medicare claim determinations or redeterminations for Medicare Part B.

First Coast offers *this information* about the claim appeals process. Once an initial claim determination is made, providers, participating physicians, and other suppliers have the right to appeal. Physicians and other suppliers who do not take assignment on claims have limited appeal rights.

Reconsiderations requested on or before February 13, 2017, will continue to be processed by the existing Part A East QIC, Maximus Federal Services, Inc. (Maximus). Since Maximus will be processing appeals received prior to February 14, 2017, there will be a short transition period during which both Maximus and C2C will issue decisions.

This change affects providers in Florida, Puerto Rico, and the US Virgin Islands, as well as those in the following states: Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, and Washington DC.

# 2016 'Medicare Part B Participating Physician and Supplier Directory'

The *Medicare Part B Participating Physician and Supplier Directory* (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing will be available no later than January 30 on the First Coast Medicare provider website at *http://medicare.fcso.com/MEDPARD/*.

Source: Pub 100-04, Transmittal 3648, CR 9794

# Provider enrollment application fee amount for 2017

On November 7, the Centers for Medicare & Medicaid Services (CMS) issued a notice: Provider Enrollment Application Fee Amount for Calendar Year 2017 [CMS–6071–N].

Effective January 1, 2017, the 2017 application fee is $560 for institutional providers that are:

- Initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP);
- Revalidating their Medicare, Medicaid, or CHIP enrollment; or
- Adding a new Medicare practice location.

This fee is required with any enrollment application submitted from January 1, 2017, through December 31, 2017.

## Processing Issues

# Computed tomographic angiography of the chest, heart, and coronary arteries – claims may have been denied in error

### Issue

Claims submitted for computed tomographic angiography of the chest, heart, and coronary arteries (procedure codes 75571-75574) between October 1, 2015, and September 5, 2016, may have been denied in error when billed with diagnosis codes I35.0, I35.1, I35.2, I35.8, I48.0, I48.1, I48.2, and I48.91.

### Resolution

This error was corrected September 6, 2016. Claims processed on or after September 6, 2016, were adjudicated correctly. First Coast Service Options Inc. will perform adjustments to correct the errors on all the affected claims.

### Status/date resolved

Closed/September 6, 2016.

### Provider action

No action is required by the provider.

### Current processing issues

Here is a link to a *table of current processing issues* for both Part A and Part B.

# Upcoming provider outreach and educational events

## Getting to know Cotiviti (Part A/B)

**Date: Thursday, February 23**
**Time: 10:00 a.m.-11:00 a.m.**
**Type of Event:** Webcast
*https://medicare.fcso.com/Events/0366061.asp*

## First Coast and CGS Administrators collaborative webcast: Nebulizers and inhalation medication

**Date: Wednesday, March 8**
**Time: 12:30-2:00 p.m.**
**Type of Event:** Webcast
*https://medicare.fcso.com/Events/0366842.asp*

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

## Two easy ways to register

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

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

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

**Please Note:**

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, *medicare.fcso.com*, 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®

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

# MLN Connects® for January 5, 2017

## Editor's Note

Best wishes for a happy and healthy 2017. Your MLN Connects® Provider eNews has a new name and design for the New Year. *Let us know* what you think. MLN Connects® still delivers the weekly Medicare news you expect but with a fresh new style from the *Medicare Learning Network® (MLN)*.

*MLN Connects® for January 5, 2017*

*View this edition as a PDF*

## News & Announcements

- Apply for Clinical Practice Improvement Activities and Measurement Study by January 31
- Updated ESRD PPS Website
- Comparative Billing Report on Physical Therapy in February
- EHR Incentive Programs: New Attestation Resources
- Implementation Guide for QRDA-III Eligible Clinician Programs Available
- January Quarterly Provider Update Available
- Get Your Patients Off to a Healthy Start in 2017

## Provider Compliance

- Duplicate Claims Will Not be Paid

## Claims, Pricers & Codes

- Fee Schedule Amounts for Group 3 Power Wheelchair Accessories and Cushions

## Upcoming Events

- ESRD QIP: Payment Year 2020 Final Rule Call — January 17
- Home Health Groupings Model Technical Report Call — January 18
- Hospice Quality Reporting Program Provider Training — January 18
- Home Health Quality of Patient Care Star Rating Call — January 19
- Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

## Medicare Learning Network® Publications & Multimedia

- Quality Payment Program Video Presentation — New
- Hospital Settlement Call: Audio Recording and Transcript — New
- Medicare Overpayments Fact Sheet — Revised
- PECOS for Provider and Supplier Organizations Fact Sheet — Revised
- Long-Term Care Hospital Prospective Payment System Booklet — Reminder
- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet — Reminder

# MLN Connects® for January 12, 2017

*MLN Connects® for January 12, 2017*
*View this edition as a PDF*

## News & Announcements

- Addressing the Opioid Epidemic: Keeping Medicare and Medicaid Beneficiaries Healthy
- Post-Acute Care TOH Quality Measures Pilot Study: Respond by January 17
- Clinical Laboratories: Prepare Now to Report Lab Data through March 31
- Chronic Care Management Services Changes for 2017
- eCQI Resource Center Integrated with USHIK
- eCQM Value Sets for 2017 Performance Period: Addendum Available
- Medicare Quality Programs: ICD-10 Code Updates and Impact to 4th Quarter 2016
- January is Cervical Health Awareness Month

## Provider Compliance

- CMS Provider Minute: CT Scans Video

## Upcoming Events

- ESRD QIP: Payment Year 2020 Final Rule Call — January 17
- Home Health Groupings Model Technical Report Call — January 18
- Home Health Quality of Patient Care Star Rating Call — January 19
- Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

## Medicare Learning Network® Publications & Multimedia

- Additional Guidance for Clinical Laboratories as Data Reporting Begins MLN Matters® Article — New
- Revised CMS 855S Application: DMEPOS Suppliers MLN Matters® Article — New
- Chronic Care Management Services Changes for 2017 Fact Sheet — New
- How to Use the Medicare Coverage Database Booklet — Revised
- SNF Prospective Payment System Booklet — Revised
- Acute Care Hospital Inpatient Prospective Payment System Booklet — Revised
- HH Prospective Payment System Booklet — Revised
- IRF Prospective Payment System Fact Sheet — Revised
- Chronic Care Management Services Fact Sheet — Revised
- Medicare Vision Services Fact Sheet — Revised
- Swing Bed Services Fact Sheet — Revised
- Mass Immunizers and Roster Billing Fact Sheet — Revised



## SPOT

from front page

- Intensive behavioral therapy for cardiovascular disease
- Intensive behavioral therapy for obesity
- Mammography screening
- Pap test screening
- Pelvic screening exam
- Prostate cancer screening
- Smoking cessation

Using SPOT to access *preventive services information* for your patient may significantly reduce your number of claim denials by checking the preventive services information before performing a test and providing the service.

"Once we had access to SPOT, I went in and pulled the first two months of claims data through the provider data summary (PDS) report," said *Tracie Jones, a Medicare billing manager for Simon-Med facilities in Central Florida*. "Most, if not all, of the denial codes we had were related to routine ultrasound tests and preventative exams. One procedure with an extraordinary high number of denials was DXA, a bone density test for measuring bone mineral density that is only covered by Medicare once every two years, Jones explained. "We worked with our scheduling department to make sure we were only performing the DXA test according to Medicare guidelines."

With SPOT, Medicare providers have several tools available to diagnose, correct, and prevent denied claims. SPOT gives you the ability to view claims status and patient eligibility information online, conduct detailed data analysis at the claim and provider levels, reopen claims to make clerical corrections on multiple lines, and submit redeterminations and additional development responses (ADRs). First Coast offers SPOT to providers at no charge.

### How to get your SPOT account

First Coast *provides a step-by-step guide* to assist you in establishing your SPOT account.

# MLN Connects® for January 19, 2017

*MLN Connects® for January 19, 2017*

*View this edition as a PDF*

## News & Announcements

- Over 40 Million Medicare Beneficiaries Utilized Free Preventive Services in 2016
- Prosthetics and Custom Fabricated Orthotics Practitioners and Suppliers: Establishment of Special Payment Provisions and Requirements
- eCQM Data: Extension of 2016 Reporting Deadline to March 13
- EHR Incentive Program: Attest to 2016 Program Requirements by February 28
- EHR Incentive Programs: Calculations for Objectives and Measures Requiring Patient Action
- CMS Releases ESRD QIP Performance Score Reports for PY 2017
- New Care Management Web page
- Provider Enrollment Application Fee Amount for 2017
- 2017 Annual Stationary Oxygen Budget Neutrality Calculations
- Glaucoma Awareness Month: Make a Resolution for Healthy Vision

## Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities

## Claims, Pricers & Codes

- OPPS Hospital Claim Issues

## Upcoming Events

- Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

## Medicare Learning Network® Publications & Multimedia

- Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 2] — New
- Medicare Parts C and D General Compliance Web-Based Training Course — Revised
- Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training Course — Revised
- Health Care Professional Frequently Used Web Pages Educational Tool — Revised
- ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT®, and HCPCS Code Sets Educational Tool — Reminder



# 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*

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

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

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

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

### Freedom of Information Act requests
FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

### Special courier service
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

# Websites

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*https://www.cms.gov*

First Coast University

*http://www.fcsouniversity.com/*

### Beneficiaries
Centers for Medicare & Medicaid Services

*https://www.medicare.gov*

# Phone numbers

### Customer service

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

### Education event registration hotline

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

### Electronic data interchange (EDI)

888-875-9779

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

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

### General inquiries

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

### Interactive voice response (IVR) system

877-847-4992

### Provider enrollment

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

### The SPOT help desk

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

# 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@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, 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
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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 |
|---|---|---|---|---|
| **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. | 40300260 | $33 | | |
| **2017 fee schedule –** The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2017, are available free of charge online at *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.<br>**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. | 40300270 | $12 | | |
| Language preference: **English** [ ] **Español** [ ] | | | | |
| | | | | |
| ***Please write legibly*** | | | 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)***

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 LCDs

# Dialysis (AV fistula and graft) vascular access maintenance – retired Part A/B LCD

### LCD ID number: L33316 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for dialysis (AV fistula and graft) vascular access maintenance is being retired effective January 1, 2017. The following CPT® codes (35475, 35476, 36147, 36148, and 36870) have been deleted and replaced with new CPT® codes (36901-36909) that address this episode of care. Absent an LCD, assuming all other requirements of the program are met, the medically reasonable and necessary threshold for coverage applies for these procedures including qualifications of the performing provider.

### Effective date

This LCD retirement is effective for services rendered **on or after January 1, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.


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

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

# Oprelvekin (Neumega®) – retired Part B LCD

### LCD ID number: L33926 (Florida, Puerto Rico/ U.S. Virgin Islands)

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

Of note, drugs approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective when used for indications specified on the labeling. Label and Off-label Coverage of Outpatient Drugs and Biologicals LCD (L33915) outlines general coverage criteria for drugs approved for marketing by the FDA labeled use, as well as the off-labeled use in the absence of a national coverage determination (NCD) or a Medicare administrative contractor LCD or published article.

### Effective date

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

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

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

## Revisions to LCDs

# Evaluation and management services in a nursing facility – revision to the Part A and Part B LCD

### LCD ID number: L36230 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 9754 (October 2016 Integrated Outpatient Code Editor (I/OCE) Specifications) and CR 9749 (Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October CY 2016 Update), the local coverage determination (LCD) for evaluation and management services in a nursing facility was revised to add HCPCS code G9685 (evaluation and management of a beneficiary's acute change in condition in a nursing facility) to the "CPT®/HCPCS Codes" section of the LCD.

### Effective date

This LCD revision is effective for claims processed **on or after January 17, 2017**, for services rendered **on or after October 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

# Intravenous Immune Globulin – revision to the Part A and Part B LCD

### LCD ID number: L34007 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request to include a diagnosis code for antibody mediated rejection (AMR) post kidney transplant, the local coverage determination (LCD) for intravenous immune globulin was revised to add ICD-10-CM diagnosis code T86.11 (kidney transplant rejection) to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

### Effective date

This LCD revision is effective for services rendered **on or after January 17, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.


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# Ophthalmoscopy – revision to the Part A and Part B LCD

### LCD ID number: L34017 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a request to include a diagnosis code range for the local coverage determination (LCD) for Ophthalmoscopy, the LCD was revised to include ICD-10 code range E10.3291–E10.3299 (diabetes Mellitus with mild non-proliferative diabetic retinopathy without macular edema) in 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 January 9, 2017**, for services rendered **on or after October 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.


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

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

# Rituximab (Rituxan®) – revision to the Part A and Part B LCD

### LCD ID number: L33746 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request to include a diagnosis code for antibody mediated rejection (AMR) post kidney transplant, the local coverage determination (LCD) for rituximab (Rituxan®) was revised to add ICD-10-CM diagnosis code T86.11 (kidney transplant rejection) to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

### Effective date

This LCD revision is effective for services rendered **on or after January 17, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

# Therapy and Rehabilitation Services – revision to the Part A and Part B LCD

### LCD ID number: L33413 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 9861, ICD-10 Coding Revisions to National Coverage Determination (NCDs), the Centers for Medicare & Medicaid Services (CMS) has instructed contractors to remove all associated diagnosis codes in current editing for CPT® code 97026 (application of a modality to 1 or more areas; infrared) effective October 1, 2015, as infrared therapy is noncovered for all indications. Therefore, the local coverage determination (LCD) for therapy and rehabilitation services was revised to remove all associated language and diagnosis codes for CPT® code 97026 as infrared therapy is noncovered for all indications.

### Effective date

This LCD revision is effective for claims processed **on or after January 20, 2017**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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