Medicare B CONNECTION
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FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
March 2017

In this issue

Medicare travel allowance fees for collection of clinical laboratory specimens

Provider types affected

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

Provider action needed

Change request (CR) 9960 revises the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for 2017. Make sure that your billing staffs are aware of these changes.

Background

The travel codes allow for payment either on a per mileage basis (P9603) or on a flat-rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. MAC discretion allows the contractor to choose either a mileage basis or a flat rate, and how to set each type of allowance.

Because audits have shown that some laboratories abused the per mileage fee basis by claiming travel mileage in excess of the minimum distance necessary for a laboratory technician to travel for specimen collection, many MACs established local policy to pay based on a flat-rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip. This applies to both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the

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

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

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.

ICD-10 coding revisions to national coverage determination

Provider types affected

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

Provider action needed

Change Request (CR) 9861 is the 10th maintenance update of ICD-10 conversions and other coding updates specific to national coverage determinations (NCDs).

The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, CR 8691, CR 9087, CR 9252, CR 9540, CR 9631, and CR 9751; while others are the result of revisions required to other NCD-related CRs released separately. *MLN Matters*® *articles* MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, MM9540, MM9631, MM9751 contain information pertaining to these CR's.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies.

In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. There may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable, as of October 1, 2015.

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed.

CR 9861 makes adjustments to the following 16 NCDs:

- NCD 40.1 - Diabetes Outpatient Self-Management Training
- NCD 40.7 - Outpatient Intravenous Insulin Treatment
- NCD 80.2 - Photodynamic Therapy (also NCD 80.2.1, 80.3, 80.3.1)
- NCD 80.11 - Vitrectomy
- NCD 100.1 - Bariatric Surgery
- NCD 110.4 – Extracorporeal Photopheresis
- NCD 110.18 - Aprepitant
- NCD 110.23 - Stem Cell Transplantation
- NCD 180.1 - Medical Nutrition Therapy
- NCD 190.1 – Histocompatibility Testing
- NCD 210.3 - Colorectal Cancer Screening
- NCD 220.4 - Mammograms
- NCD 220.6.17 - Positron Emission Tomography (PET) for Solid Tumors
- NCD 260.3.1 - Islet Cell Transplants
- NCD 260.5 - Intestinal and Multi-Visceral Transplants
- NCD 270.6 - Infrared Therapy Devices

The spreadsheets for the above NCDs are available at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9861.zip*.

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

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: remittance advice remark code (RARC) N386 with claim adjustment reason code (CARC) 50, 96, and/or 119, with group code PR (Patient Responsibility) or group code CO (Contractual Obligation), as appropriate.

Your MAC will not search their files to adjust previously processed claims but will adjust any claims that you bring to their attention if found appropriate to do so.

Additional information

The official instruction, CR 9861, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1792OTN.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: MM9861
Related Change Request (CR) #: CR 9861
Related CR Release Date: February 3, 2017
Effective Date: October 1, 2016 - Unless otherwise noted in individual requirements
Related CR Transmittal #: R1792OTN
Implementation Date: March 3, 2017 - MAC local systems; April 3, 2017 - FISS, MCS, CWF Shared systems

April 2017 quarterly update for 2017 DMEPOS fee schedule

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

Background

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

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (§1834(a), (h), and (i)). Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, Section §1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME.

The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments.

Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

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

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

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

Section 16005 of the 21st Century Cures Act extends the effective date through June 30, 2017, to exclude adjustments to fees using information from CBPs for certain wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). As a result, the KU modifier fees have been added back to the DMEPOS fee schedule file effective January 1, 2017, and are effective for dates of service through June 30, 2017.

The fees for items denoted with the HCPCS modifier 'KU' represent the unadjusted fee schedule amounts (the 2015 fee schedule amount updated by the 2016 and 2017 DMEPOS covered item update factor of 0.7 percent). The applicable complex rehabilitative wheelchair accessory codes are listed in CR 9520 (Transmittal 3535, dated June 7, 2016).

Note for change request 8822 reclassification of certain DME to the capped rental payment category

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

For dates of service on or after July 1, 2016, through December 31, 2016, these HCPCS codes were reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the nine Round 1 Recompete (Round 1 2014) Competitive Bidding Areas (CBAs). Program instructions on these changes were issued in CR 8822 (Transmittal 1626, dated February 19, 2016) and CR 8566 (Transmittal 1332, dated January 2, 2014).

Related *MLN Matters* articles are at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8822.pdf* and

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https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8566.pdf, respectively.

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

Example

- Procedure code: E2370
- Units of Service = 2
- Modifiers: RR, LT, RT, 99 (RB, KX reported in additional narrative)

Payment for oxygen volume adjustments and portable oxygen equipment

CR 9848 (Transmittal 3679, dated December 16, 2016) titled Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment, updated the "Medicare Claims Processing Manual" (Pub.100-04, chapter 20, section 130.6) to clarify billing when the prescribed amount of stationary oxygen exceeds 4 liters per minute (LPM) and portable oxygen is prescribed. The QF modifier is used to denote when the oxygen flow exceeds 4 LPM and portable oxygen is prescribed.

The Social Security Act (§ 1834(a)(5)(C) and (D)) requires that when there is an oxygen flow rate that exceeds 4 LPM that the Medicare payment amount be the higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1392) or the portable oxygen add-on amount (E0431, E0433, E0434, E1392, or K0738), and never both.

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

Effective April 1, 2017, the modifier "QF" should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 liters per minute (LPM).

Additional information

The official instruction, CR 9988 issued to your MAC regarding this change, refer *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3729CP.pdf*.

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

Document history

Date	Description
March 6, 2017	Article released

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Related Change Request (CR) #: CR 9988
Related CR Release Date: March 3, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3729CP
Implementation Date: April 3, 2017

Your Feedback Matters

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

April 2017 update to the Medicare physician fee schedule database

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 and subject to the Medicare physician fee schedule (MPFS).

Provider action needed

Change request (CR) 9977 informs MACs about changes to the MPFS payment files. While the changes will be implemented in Medicare systems on April 3, the changes are effective January 1, 2017. Note that MACs need not search their files to either retract payment for claims already paid or to retroactively pay claims already processed. However, the MACs will adjust such claims that you bring to their attention. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to the MACs based upon the 2017 MPFS Final Rule, published in the *Federal Register* on November 15, 2016, to be effective for services furnished between January 1, 2017, and December 31, 2017.

Below is a summary of the changes for the April update to the 2017 MPFSDB. These changes are effective for dates of service on or after January 1, 2017

CPT®/HCPCS Code	MOD	Action
G0477		Procedure Status = I
G0478		Procedure Status = I
G0479		Procedure Status = I
22867		Assistant surgery indicator = 2
22869		Assistant surgery indicator = 2
76519	26	Bilateral surgery indicator = 3
92136	26	Bilateral surgery indicator = 3
97161		Non-facility & facility PE RVU = 1.00
97162		Non-facility & facility PE RVU = 1.00
97163		Non-facility & facility PE RVU = 1.00
97165		Non-facility & facility PE RVU = 1.32
97166		Non-facility & facility PE RVU = 1.32
97167		Non-facility & facility PE RVU = 1.32
97168		Non-facility & facility PE RVU = 0.93

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

CPT® code	Short descriptor	Long descriptor
0001U	RBC DNA HEA 35 AG 11 BLD GRP	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported
0002U	ONC CLRCT 3 UR METAB ALG PLP	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps
0003U	ONC OVAR 5 PRTN SER ALG SCOR	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score

Additional information

The official instruction, CR 9977, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-guidance/Guidance/Transmittals/2017Downloads/R3719CP.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: MM9977
Related Change Request (CR) #: CR 9977
Related CR Release Date: February 15, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3719CP
Implementation Date: April 3, 2017

New MSP type for liability set-aside arrangements

Provider types affected

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

What you need to know

This article is based on change request (CR) 9893. To comply with the Government Accountability Office (GAO) final report entitled *Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333)*, the Centers for Medicare & Medicaid Services (CMS) will establish two new set-aside processes: a liability insurance Medicare set-aside arrangement (LMSA), and a no-fault insurance Medicare set-aside arrangement (NFMSA).

An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare. Please be sure your billing staffs are aware of these changes.

Background

CMS will establish two (2) new set-aside processes: a Liability Medicare Set-aside Arrangement (LMSA), and a No-Fault Medicare Set-aside Arrangement (NFMSA).

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

Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA or NFMSA funds. However, Liability and No- Fault MSP claims that do not have a Medicare Set-Aside Arrangement (MSA) will continue to be processed under current MSP claims processing instructions.

Key points of CR 9893

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

In addition to CARC 201 and Group Code PR, when denying a claim based upon the existence of an open LMSA or NFMSA MSP record, your MAC will include the following Remittance Advice Remark Codes (RARCs) as appropriate to the situation:

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

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

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

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

Additional information

The official instruction, CR 9893, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1787OTN.pdf*.

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

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

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

MLN Matters® Number: MM9893
Related Change Request (CR) #: CR 9893
Related CR Release Date: February 3, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1787OTN
Implementation Date: October 2, 2017

April 2017 update of the ambulatory surgical center payment system

Provider types affected

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

Provider Action Needed

Change request (CR) 9998, from which this article was developed, describes changes to and billing instructions for various payment policies implemented in the April 2017 ASC payment system update.

This Recurring Update Notification applies to Chapter 14, Section 10 of the *Medicare Claims Processing Manual* (Pub. 100-04), available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf* on the Centers for Medicare & Medicaid Services (CMS) website. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS).

Background

Included in this CR are updates to payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files). There is no ASC fee schedule (ASCFS) being issued this quarter.

Drugs, Biologicals, and Radiopharmaceuticals

ASC drugs and biologicals with OPPS pass-through status effective April 1, 2017

For 2017, several new HCPCS codes, with OPPS pass-through status, 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 in Table 1.

Table 1: ASC Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2017

HCPCS code	Long desc.	Short desc.	ASC PI
C9484	Injection, eteplirsen, 10 mg	Injection, eteplirsen	K2
C9485	Injection, olaratumab, 10 mg	Injection, olaratumab	K2
C9486	Injection, granisetron extended release, 0.1 mg	Inj, granisetron ext	K2
C9487	Ustekinumab, for intravenous injection, 1 mg		K2

HCPCS code	Long desc.	Short desc.	ASC PI
C9488	Injection, conivaptan hydrochloride, 1 mg	Conivaptan HCL	K2
J7328	Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg	Gel-syn injection 0.1 mg	K2

Drugs and biologicals with payments based on average sales price (ASP) effective April 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. Updated payment rates effective April 1, 2017, and drug price restatements can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html*.

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 will be accessible on the first date of the quarter

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at *http://www.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 contractor adjustment of the previously processed claims.

Revised payment indicator for HCPCS code J1130 effective January 1, 2017

The status indicator for HCPCS code J1130 (Injection, diclofenac sodium, 0.5 mg) will change from ASC PI=Y5 (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) to ASC PI=K2 (Drugs and biological paid separately when provided integral to a surgical procedure on ASC list) in the April 2017 update. This status indicator correction will be retroactive to January 1, 2017. The correction is shown in Table 2.

Table 2: Revised Payment Indicator for HCPCS Code J1130 Effective January 1, 2017

HCPCS code	Long desc.	Short descr	ASC PI
J1130	Injection, diclofenac sodium, 0.5 mg	Inj diclofenac sodium 0.5mg	K2

HCPCS Code C9744

As a reminder to ASCs, HCPCS Code C9744 (Ultrasound, abdominal, with contrast) may be used to describe use of a contrast agent in ultrasonography of the liver, kidneys, and/or bladder.

Reassignment of skin substitute product from the low-cost group to the high-cost group

Four skin substitute products have been reassigned from the low-cost skin substitute group to the high-cost skin substitute group based on updated pricing information. The HCPCS codes are Q4161, Q4169, Q4173, and Q4175. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). These products are shown in Table 3.

Table 3: Reassignment of skin substitute product from the low-cost group to the high-cost group effective April 1, 2017

2017 HCPCS code	2017 short desc	ASC PI	Low/High Cost Skin Substitute
Q4161	Bio-Connekt per square cm	N1	High
Q4169	Artacent wound, per square cm	N1	High
Q4173	Palingen or palingen xplus, per sq cm	N1	High
Q4175	Miroderm, per square cm	N1	High

Removal of skin substitute product from the high/low-cost skin substitute table

HCPCS Code Q4171 was inadvertently included in the High/Low-Cost Skin Substitute table. Effective April 2017, Q4171 is removed from the High/Low-Cost Skin Substitute table. As a reminder, ASCs should not separately bill for packaged skin substitutes (ASC PI=N1). This product is listed in Table 4.

Table 4: Skin substitute product removed from high/low-cost skin substitute table effective April 1, 2017

2017 HCPCS code	2017 short desc.	ASC PI
Q4171	Interfyl, 1 mg	N1

Coverage determinations:

The fact that a drug, device, procedure, or service is assigned an 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. 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.

Additional information

The official instruction, CR 9998 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3726CP.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/*.

Additional information

Date	Description
March 6, 2017	Article release

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Related Change Request (CR) #: CR 9998
Related CR Release Date: March 3, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3726CP
Implementation Date: April 3, 2017

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flat rate is set by the MAC.

• Per Mile Travel Allowance (P9603) - The per mile travel allowance is to be used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using the Federal mileage rate of $0.535 per mile plus an additional $0.45 per mile to cover the technician's time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $0.99 per mile ($0.985 is rounded up for system purposes) if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the Clinical Laboratory Fee Schedule (CLFS), as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

Per Flat-Rate Trip Basis Travel Allowance (P9604) - The per flat-rate trip basis travel allowance is $9.85.

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.

Additional information

The official instruction, CR 9960, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3717CP.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 Release Date: February 10, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3717CP
Implementation Date: May 12, 2017

Correct your claims on the 'SPOT'

The SPOT offers registered users the time-saving advantage of not only viewing claim data online but also the option of correcting clerical errors on their eligible Part B claims quickly, easily, and securely – online. Review *this tutorial* on how to get started correcting claims online.

The SPOT tutorial is available at *https://medicare.fcso.com/Help/276733.asp*.

Implementation of new influenza virus vaccine code

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.

What you need to know

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

Background

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

- Effective for dates of service on or after August 1, 2017, MACs will pay for code 90682 using the Centers for Medicare & Medicaid Services (CMS) seasonal influenza vaccines pricing at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* to determine the payment rate for influenza virus vaccine code 90682.
- Pay for vaccine code 90682 on institutional claims as follows:
    - Hospitals – types of bill (TOB) 12x and 13x, skilled nursing facilities (SNFs) – TOB 22x and 23x, home health agencies (HHAs) – TOB 34x, hospital-based renal dialysis facilities (RDFs) – TOB 72x, and critical access hospitals (CAHs) – TOB 85x, based on reasonable cost
    - Indian health service (IHS) hospitals – TOB 12x, and 13x, IHS CAHs – TOB 85x, and hospices (81x and 82x) based on the lower of the actual charge or 95 percent of the average wholesale price (AWP)
    - Comprehensive outpatient rehabilitation facility (CORF) – TOB 75x, and independent RDFs – TOB 72x, based on the lower of actual charge or 95 percent of the AWP
- MACs will pay at discretion claims for code 90682 with dates of service July 1, 2017, through July 31, 2017.
- MACs will return to the provider (RTP) institutional claims if submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017.
- MACs will deny Part B claims submitted with code 90682 for dates of service January 1, 2017, through June 30, 2017, using the following messages:
    - Claim adjustment reason code: 181 – "Procedure code was invalid on the date of service."
    - Remittance advice remark code: N56 – "Procedure code billed is not correct/valid for the services billed or the date of service billed."
    - Group code: CO (Contractual Obligation)

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

Additional information

The official instruction, CR 9876, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3711CP.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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Episode payment model operations

Provider types affected

This *MLN Matters*® article is intended for physicians and acute care hospitals that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

In August 2016, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule that planned to implement an additional set of models that share many design features of the comprehensive care for joint replacement (CJR) model, but focus on three different clinical conditions. The new episode payment models (EPMs) will focus on acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip and femur fracture treatment (SHFFT), most frequently hip pinning.

These models will begin in 2017 and run for 5 years.

Change request (CR) 9916 is intended to prepare Medicare's claims processing systems for implementation of episode payment models (EPMs). CR 9916 directs the MACs to conduct beneficiary eligibility checks, including for overall eligibility for the EPMs as well as for additional related services such as post-discharge home visits Under EPM, CMS will allow a beneficiary in certain EPM episodes to receive skilled nursing facility (SNF) services without having to meet the three-day requirement in performance years two through five of the model. This will allow payment of claims for SNF services delivered to beneficiaries at eligible sites.

Background

The Social Security Act (Section 1115A) authorizes CMS to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries. CMS has previously used its legislative authority to create payment models, such as the bundled payments for care improvement (BPCI) initiative, to test bundled payments.

In April 2016, CMS began testing a new bundled payment model called the comprehensive care for joint replacement (CJR) model. The CJR Model requires that hospitals test bundled payments for lower extremity joint replacement (LEJR) episodes in multiple geographic areas. The CJR model is designed to promote quality and financial accountability for episodes of care surrounding a LEJR and test whether bundled payments to acute care hospitals for LEJR episodes of care can reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

In December 2016, CMS published a final rule that implements an additional set of models that share many design features of the CJR Model, but focus on three different clinical conditions, namely:

- Acute myocardial infarction (AMI),
- Coronary artery bypass graft (CABG), and
- Surgical hip and femur fracture treatment (SHFFT), most frequently hip pinning.

These models will begin in 2017 and run for five performance years (PY).

- PY1: July 1, 2017 – December 31, 2017
- PY2: January 1, 2018 - December 31, 2018
- PY3: January 1, 2019 - December 31, 2019
- PY4: January 1, 2020 - December 31, 2020
- PY5: January 1, 2021 - December 31, 2021

Under the EPMs, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for AMI, CABG, and/or SHFFT episodes. All related care within 90 days of hospital discharge will be included in the episode of care.

The final rule also finalized the concurrent implementation of a cardiac rehabilitation incentive payment (CR) model. The CR Model will provide incentive payments to hospitals that discharge patients following an AMI or CABG with referral to cardiac rehabilitation/intensive cardiac rehabilitation, an underutilized but effective treatment for patients recovering from an acute cardiac event. Incentive payments will be tied to the number of cardiac rehabilitation/intensive cardiac rehabilitation visits that the patient completes. The CR model will be implemented in two separate cohorts in order to test its efficacy, one in the same regions as the AMI and CABG models, and one in purely fee-for-service (FFS) regions.

EPM episodes of care

Medicare currently pays for AMI, CABG, and SHFFT procedures under the Inpatient Prospective Payment System (IPPS) through Medicare severity diagnosis related groups (MS-DRGs). Under the EPMs, episodes would begin with admission to an acute care hospital when a claim is assigned to an MS-DRG included in one of the EPMs upon beneficiary discharge and paid under the IPPS, and would end 90 days after the date of discharge from the acute care hospital. The episode would include the inpatient procedure, inpatient stay, and all related care as defined under the model that is covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care, and physician services.

EPM participants

Participants would be acute care hospitals, who would be the episode initiators (that is, the entity where the episode begins) and bear quality and episode payment accountability under the EPMs. CMS will require all hospitals paid under the IPPS and located in selected

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geographic areas to participate in the EPMs, with limited exceptions for those hospitals currently participating in BPCI model 2 or model 4 for the same clinical episodes. The care for eligible beneficiaries who receive care at these hospitals will automatically be included in the model.

EPM model beneficiary inclusion criteria

The defined population of Medicare beneficiaries whose care will be included in the EPMs must meet the following criteria upon admission to the anchor hospitalization:

• The beneficiary is enrolled in Medicare Part A and Part B throughout the duration of the episode.

• The beneficiary's eligibility for Medicare is not on the basis of the End Stage Renal Disease (ESRD) benefit.

• The beneficiary is not prospectively assigned to an accountable care organization (ACO) in the next generation ACO model, an ACO in a track of the comprehensive ESRD care model incorporating downside risk for financial losses, or a Shared Savings Program ACO in Track 3.

• The beneficiary is not enrolled in any managed care plan.

• The beneficiary is not covered under a United Mine Workers of America health plan.

• Medicare is the primary payer.

EPM episode reconciliation activities

CMS will continue paying hospitals and other providers according to the conventional Medicare FFS rules during all performance years. After each performance year, the Medicare payments for services included in the episode for an EPM beneficiary will be aggregated to calculate an actual episode payment. The actual episode payment will then be compared against an established EPM target price that reflects a discount over expected episode spending based on a blend of hospital-specific and regional historical episode data.

Based on this comparison and taking into consideration episode quality performance based on the composite quality score calculated for each hospital each performance year, CMS will determine whether reconciliation payment to (applicable for PYs 1-5) or recoupment from (applicable for some hospitals PYs 3-5 and other hospitals PYs 2-5) the hospital will be conducted. In addition, in order to be eligible for a reconciliation payment, the hospital must meet the applicable minimum composite quality score. Calculation of these reconciliation or recoupment amounts will be conducted by a specialty contractor annually and paid or recouped beginning in 2018.

Identifying EPM claims

To validate the retroactive identification of EPM episodes, CMS is associating the Demonstration Code 79 with the EPM initiative. This code will be used to operationalize the waiver of the 3-day stay requirement for covered SNF services. This waiver will be effective in conjunction with the introduction of downside risk to the AMI episodes ending on or after January 1, 2019 (and beginning on or after 10/4/2018) and it will allow for the payment of SNF Claims for beneficiaries who have not met the 3-day hospital stay requirement for claims containing the Demonstration code 79.3

SNF 3-Day waiver

In order to provide more comprehensive care across the post-acute spectrum and support the ability of participant hospitals to coordinate the care of beneficiaries, CMS will conditionally waive the 3-day stay requirement for beneficiaries for covered SNF services in AMI EPM episodes, effective with AMI EPM episodes that start on or after payment year three of the model (January 1, 2019).

Under Medicare rules, in order for Medicare to pay for SNF services, a beneficiary must have a qualifying hospital stay of at least three consecutive days (counting the day of hospital admission but not the day of discharge). Additional information regarding the SNF benefit is available in the *Medicare Benefit Manual*, (Pub 100–02, Chapter 8, Skilled Nursing Facility Services).

As of October 4, 2018, CR9916 allows for payment of SNF claims without a 3-day hospital stay (that is, CMS will waive the 3-day hospital stay requirement when all of the following conditions are met:

• The hospitalization does not meet the prerequisite hospital stay of at least 3 consecutive days for Part A coverage of extended care services in a SNF. If the hospital stay would lead to covered SNF services in the absence of the waiver, then the waiver is not necessary for the stay.

• The discharge is from a hospital participating in an EPM. Participants can be confirmed by a posted file on the CMS website and will be shared with MACs on a monthly basis.

The beneficiary must have been discharged from the EPM hospital for one of the specified MS–DRGs (231-236, 246-251, 280-282) within 30 days prior to the initiation of SNF services. (Note that this list of MS-DRGs may need to be updated prior to October 4, 2018 if annual changes to the IPPS MS-DRGs add, combine or delete any of these DRGs.)

• The beneficiary meets the criteria for inclusion in an EPM at the time of SNF admission: That is, he or she is enrolled in Part A and Part B, eligibility is not on the basis of ESRD, is not enrolled in any managed care plan, is not covered under a United Mine Workers of American health plan, is not prospectively assigned to an ACO in the next generation ACO model, an ACO in a track of the comprehensive ESRD care model incorporating downside risk for financial losses, or a shared savings program ACO in Track 3, and Medicare is the primary payer.

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• The waiver will apply if the SNF is qualified to admit EPM beneficiaries under the waiver. A list of qualified SNFs will be communicated to MACs and CMS Shared Systems Maintainers via a quarterly list, developed by CMS and posted to the CMS website on a quarterly basis. The list will contain those SNFs with an overall star rating of three stars or better for at least 7 of the preceding 12 months of the rolling data used to create the quarterly list.

• The SNF must include demonstration code 79 in the treatment authorization field on claims that qualify for the SNF waiver under the EPM. Note: The waiver is not valid for swing bed (TOB 18X) stays.

• Other requirements. All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply.

Post-Discharge Home Visits

In order for Medicare to pay for home health services, a beneficiary must be determined to be "homebound" and in need of skilled care (skilled nursing, physical therapy or speech-language pathology services). Additional information regarding the home health benefit is available in the *Medicare Benefit Manual* (Pub 100–02, Chapter 7, Home Health Services.)

Medicare policy allows physicians and non-physician practitioners (NPPs) to furnish and bill for visits to any beneficiary's home or place of residence under the physician fee schedule (PFS). Medicare policy also allows licensed clinical staff to furnish services "incident to" the physician or NPP visit at a beneficiary's home when such services are provided under the direct supervision of the physician or NPP.

Licensed clinical staff may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform ordered services. Additional information regarding the "incident to" requirements is available in the *Medicare Benefit Manual* (Pub 100–02, Chapter 15, Covered Medical and Other Health Services, Sections 60-60.4.1).

For those EPM beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment but who are not homebound or otherwise eligible for the Medicare home health benefit, CMS will waive the "incident-to" direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence anytime during the episode, subject to the following conditions:

- Licensed clinical staff will furnish the service under the general supervision of a physician or NPP, who may be either an employee or a contractor of the participant hospital.
- Services will be billed under the PFS by the supervising physician or NPP or by the hospital to which the supervising physician has reassigned his or her billing rights. Up to nine post discharge home visits can be billed and paid per beneficiary during each 90-day post-anchor hospitalization EPM episode.
- The service will be billed with HCPCS G-code 9863, which is specific to the AMI, CABG, or SHFFT model home visits for patient assessment. These visits must be performed by clinical staff for an individual not considered homebound, and may include but not necessarily be limited to patient assessment of clinical status, safety/fall prevention, functional status/ambulation, medication reconciliation/management, compliance with orders/plan of care, performance of activities of daily living, and ensuring beneficiary connections to community and other services. The HCPCS G-code is approved for use only in the Medicare approved AMI, CABG, or SHFFT models and may not be billed for a 30-day period covered by a transitional care management code and paid under the PFS.
- The service cannot be furnished to an EPM beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.

As described in the *Medicare Claims Processing Manual* (Pub 100-04, Chapter 12, Sections 40-40.4), Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for the EPMs, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

Additional information on billing and payment for the post-discharge home visit HCPCS G-Code will be available in the July 2017 release of the Medicare physician fee schedule recurring update.

Billing and payment for telehealth services

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The

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service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service.

Additional information regarding Medicare telehealth services is available in the *Medicare Benefit Policy Manual* (Pub 100-02, Chapter 15, Section 270) and the *Medicare Claims Processing Manual* (Pub 100-04, Chapter 12, Section 190).

Under EPM, CMS will allow a beneficiary in an EPM episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in an EPM episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.

- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the EPM model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the EPM model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.
- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the proposed EPM episode definition.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).
- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the EPM model that reflect the home setting.
- For level 4 and 5 EPM telehealth home visits, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient's home during the visit or document the reason that such a high-level visit would not require such personnel.
- Physicians billing distant site telehealth services under these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.
- The facility fee paid by Medicare to an originating site for a telehealth service would be waived if the service was originated in the beneficiary's home.

Additional information on billing and payment for the telehealth home visit HCPCS G-Codes will be available in the July 2017 release of the MPFS recurring update.

Cardiac rehabilitation (CR) incentive payment model billing and payment

CR services are covered by Medicare and have been shown by research to improve health outcomes. However, these cardiac rehabilitation services have been historically under-utilized by Medicare beneficiaries. The CR incentive payment model is designed to provide participant hospitals in 90 different metropolitan statistical areas with incentive payments to encourage the use of cardiac rehabilitation services for beneficiaries in certain MS-DRGs. Providers and suppliers will continue to be paid under the usual Medicare payment system rules and procedures.

Following the end of a model performance year, depending on beneficiaries' utilization of CR/Intensive CR services, participant hospitals may receive an additional incentive payment from Medicare. CMS has provided a waiver of the definition of a physician to include a physician or NPP (defined for the purposes of this waiver as a physician assistant, nurse practitioner, or clinical nurse specialist) in performing specific physician functions in conjunction with the delivery of CR services to EPM-CR and FFS-CR beneficiaries during AMI care periods and CABG care periods.

Additional information

The official instruction, CR 9916, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R169DEMO.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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Updated editing of professional therapy services

Provider types affected

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

Provider action needed

Change request (CR) 9933 instructs the MACs to apply certain coding edits to the new Current Procedural Terminology (CPT®) codes that are used to report physical therapy (PT) and occupational therapy (OT) evaluations and re-evaluations, effective January 1, 2017. Make sure your billing staffs are aware of these coding changes.

Background

Original Medicare claims processing systems contain edits to ensure claims for the evaluative procedures furnished by rehabilitative therapy clinicians – including physical therapists, occupational therapists and speech-language pathologists – are coded correctly. These edits ensure that when the codes for evaluative services are submitted, the therapy modifier (GP, GO, or GN) that reports the type of therapy plan of care is consistent with the discipline described by the evaluation or re-evaluation code. The edits also ensure that functional reporting occurs, which is to say that functional G-codes, along with severity modifiers, always accompany codes for therapy evaluative services.

These edits were applied to institutional claims in CR 9698. A related article is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9698.pdf*

For 2017, eight new CPT® codes (97161-97168) were created to replace existing codes (97001-97004) to report PT and OT evaluations and reevaluations. The new CPT code descriptors include specific components that are required for reporting as well as the typical face-to-face times.

In CR 9782, the Centers for Medicare & Medicaid Services (CMS) described the new PT and OT code sets, each comprised of three new codes for evaluation – stratified by low, moderate, and high complexity – and one code for re-evaluation.

CR 9782 designated all eight new codes as "always therapy" (always require a therapy modifier) and added them to the 2017 therapy code list located at *http://www.cms.gov/Medicare/Billing/TherapyServices/index.html*. CR 9933 applies these edits to professional claims.

For a complete listing of the new codes, their CPT® long descriptors, and related policies, see the related article for CR 9782 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9782.pdf*.

CR 9933 applies the coding requirements for certain evaluative procedures that are currently outlined in the *Medicare Claims Processing Manual (MCPM)*, Chapter 5, to the new codes for PT and OT evaluative procedures. These new PT and OT codes 97161 – 97168 were added to the applicable code lists in MCPM, Chapter 5, by CR 9698.

Key points

CR 9933 implements the following payment policies related to professional claims for therapy services for the new CPT® codes for PT and OT evaluative procedures – claims without the required information will be returned/rejected:

Therapy modifiers

The new PT and OT codes are added to the current list of evaluative procedures that require a specific therapy modifier to identify the plan of care under which the services are delivered to be on the claim for therapy services. Therapy modifiers GP, GO, or GN are required to report the type of therapy plan of care – PT, OT, or speech-language pathology, respectively. This payment policy requires that each new PT evaluative procedure code – 97161, 97162, 97163 or 97164 – to be accompanied by the GP modifier; and, (b) each new code for an OT evaluative procedure – 97165, 97166, 97167 or 97168 – be reported with the GO modifier.

In addition to other Functional Reporting requirements, Medicare payment policy requires Functional Reporting, using G-codes and severity modifiers, when an evaluative procedure is furnished and billed. This notification adds the eight new codes for PT and OT evaluations and re-evaluations – 97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168 – to the procedure code list of evaluative procedures that necessitate functional reporting. A severity modifier (CH – CN) is required to accompany each functional G-code (G8978-G8999, G9158-9176, and G9186) on the same line of service.

For each evaluative procedure code, functional reporting requires either two or three functional G-codes and related severity modifiers be on the same claim. Two G-codes are typically reported on specified claims throughout the therapy episode. However, when an evaluative service is furnished that represents a one-time therapy visit, the

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therapy clinician reports all three G-codes in the functional limitation set – G-codes for current status, goal status and discharge status.

CMS coding requirements for functional reporting applied through CR 9933 ensure that at least two G-codes in a functional set and their corresponding severity modifiers are present on the same claim with any one of the codes on this evaluative procedure code list. The required reporting of G-codes includes: (a) G-codes for current status and goal status; or, (b) G-codes for discharge status and goal status.

For the documentation requirements related to Functional Reporting, please refer to the *Medicare Benefits Policy Manual*, Chapter 15, Section 220.4, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*.

Claims coding requirements:

Therapy modifiers. Your MAC will return/reject professional claims when:

- Reporting codes 97161, 97162, 97163, or 97164 without the GP modifier.
- Reporting codes 97165, 97166, 97167, or 97168 without the GO modifier. •
- Reporting an "always therapy" code without a therapy modifier

For these returned/rejected claims, your MAC will supply the following messages:

- Group code CO
- CARC – 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.

Functional reporting. Your MAC will return/reject claims when:

- The professional claims you submit for the new therapy evaluative procedures, codes 97161-97168, without including one of the following pairs of G-codes/severity modifiers required for functional reporting: (a) A current status G-code/severity modifier paired with a goal status G-code/severity modifier; or, (b) A goal status G-code/severity modifier paired with a Discharge Status G-code/severity modifier.

Your MAC will provide the following remittance messages when returning such submissions:

- Group code of CO (contractual obligation)
- Claim adjustment reason code (CARC) – 16: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- Remittance advice remarks code (RARC) – N572: This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.

Additional information

The official instruction, CR 9933, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1775OTN.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: MM9933
Related Change Request (CR) #: CR 9933
Related CR Release Date: January 27, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R1775OTN
Implementation Date: July 3, 2017

Reprocessing of HCPCS code J7328

Issue

Healthcare Common Procedural Coding System (HCPCS) code J7328 (Hyaluronan or derivative, gel-syn) was overpaid in error for dates of service on or after January 1, 2016.

Resolution

The Medicare administrative contractor updated the payment rate to allow $365.70 per 16.8mg effective for claims processed on and after December 6, 2016.

Status/date resolved

Closed/December 6, 2016.

Provider action

Providers should submit voluntary refunds of overpaid amounts.

Current processing issues

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

Updates to the 'Medicare Claims Processing Manual' to correct remittance advice messages

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

This article is based on change request (CR) 9906, which revises Chapters 12, 17, and 23 of the *Medicare Claims Processing Manual* (the manual) to ensure that all remittance advice coding is consistent with national standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual. MACs will ensure that they apply remittance advice coding as described in the revised manual sections. Make sure that your billing staffs are aware of these changes.

Background

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, Claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) may be used. The rule requires specific codes, which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. CR 9906 updates Chapters 12, 17, and 23 of the manual to reflect the standard format and to correct any non-compliant code combinations.

Additional information

The official instruction, CR 9906, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3721CP.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: MM9906
Related Change Request (CR) #: CR 9906
Related CR Release Date: February 24, 2017
Effective Date: May 25, 2017
Related CR Transmittal #: R3721CP
Implementation Date: May 25, 2017

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

Revised CMS-855O application: Enrollment solely to order, certify or prescribe

Physicians and non-physician practitioners must use the revised CMS-855O application (Eligible ordering, certifying, and prescribing physicians and other eligible professionals) beginning January 1, 2018. The revised application will be posted on the Centers for Medicare & Medicaid Services (CMS) forms list (*https://go.usa.gov/xX3Sa*) by early summer. Medicare administrative contractors will accept both the current and revised versions of the CMS-855O through December 31, 2017. Visit the *Medicare Provider-Supplier Enrollment webpage* for more information about Medicare enrollment.

Changes to the form include:

- New title: Non-enrolled practitioners who prescribe Part D drugs also use this form.
- New specialties: Added interventional cardiology and five other specialties; oral surgeons (dentist only) split into oral surgeon and dentist.
- Now optional for providers to add an additional contact person.
- Editorial and formatting corrections in response to public comments.

Provider Enrollment Revalidation – Cycle 2

Note: *This article was revised on March 15, 2017, to update the table on page 6 and added additional information after that table. All other information is unchanged. This article was published previously in the March 2016 edition pages 34-37.*

Provider types affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), Medicare Carriers, Fiscal Intermediaries, and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements that are captured within this article.

Caution – What you need to do

1. Check *http://go.cms.gov/MedicareRevalidation* for the provider/suppliers due for revalidation;
2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:
    - Submit a revalidation application through Internet-based PECOS located at *https://pecos.cms.hhs.gov/pecos/login.do*, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
    - Complete the appropriate CMS-855 application available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html*;
    - If applicable, pay your fee by going to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do*; and
    - Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

What's ahead for your next Medicare enrollment revalidation?

Established Due Dates for Revalidation

CMS has established due dates by which the provider/supplier's revalidation application must reach the MAC in order for them to remain in compliance with Medicare's provider enrollment requirements. The due dates will generally be on the **last day of a month** (for example, June 30, July 31 or August 31). Submit your revalidation application to your MAC within 6 months of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

- The list will be available at **http://go.cms.gov/MedicareRevalidation** and will include **all** enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a "TBD" (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at **http://go.cms.gov/MedicareRevalidation** on the CMS website.

IMPORTANT: The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you

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will not be asked to revalidate and will not be reflected on the list.

- Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).
- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier's due date.

  Revalidation notices sent via email will indicate **"URGENT: Medicare Provider Enrollment Revalidation Request"** in the subject line to differentiate from other emails. If all of the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

  NOTE: Providers/suppliers who are within 2 months of their listed due dates on *http://go.cms.gov/MedicareRevalidation* ***but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.***

- To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

Large Group Coordination

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming 6 month period. A spreadsheet detailing the applicable provider's Name, National Provider Identifier (NPI) and Specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.
Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on *http://go.cms.gov/MedicareRevalidation* to determine their provider/supplier's revalidation due dates.

Unsolicited Revalidation Submissions

All unsolicited revalidation applications submitted more than 6 months in advance of the provider/supplier's due date will be ***returned***.

- What is an unsolicited revalidation?
  - If you are not due for revalidation in the current 6 month period, your due date will be listed as "TBD" (To Be Determined). This means that you do not yet have a due date for revalidation. **Please do not submit a revalidation application if there is NOT a listed due date.**
  - Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
- If your intention is to submit a change to your provider enrollment record, you must submit a *'change of information'* application using the appropriate CMS-855 form.

Submitting Your Revalidation Application

IMPORTANT: Each provider/supplier is required to revalidate their entire Medicare enrollment record.

A provider/supplier's enrollment record includes information such as the provider's individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided). This means the provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and Provider Transaction Access Numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to *https://pecos.cms.hhs.gov/pecos/login.do*. PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation

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applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html* on the CMS website.

Getting Access to PECOS:
To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as "I&A". The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.

To learn more about establishing an I&A account or to verify your ability to submit applications using PECOS, please refer to *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*.

If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the revalidation notice. You may also find a list of MAC's at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf*.

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1-866-484-8049 or at *EUSSupport@cgi.com*.

Deactivations Due to Non-Response to Revalidation or Development Requests

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

NOTE: The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will **not** be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider's liability.

Revalidation Timeline and Example

Providers/suppliers may use the following table /chart as a guide for the sequence of events through the revalidation progression.

Action	Timeframe	Example
Revalidation list posted	Approximately 6 months prior to due date	March 30, 2017
Issue large group notifications	Approximately 6 months prior to due date	March 30, 2017
MAC sends email/letter notification	75 – 90 days prior to due date	July 2 - 17, 2017
MAC sends letter for undeliverable emails	75 – 90 days prior to due date	July 2 - 17, 2017
Revalidation due date		**September 30, 2017**
Apply payment hold/issue reminder letter (group members)	Within 25 days after due date	October 25, 2017
Deactivate	60 – 75 days after due date	7

Deactivations Due to Non-Billing

Providers/suppliers that have not billed Medicare for the previous 12 consecutive months will have their Medicare billing privileges deactivated in accordance with 42 CFR §424.540. The effective date of deactivation will be 5 days from the date of the corresponding deactivation letter issued by the MACs notifying the providers/suppliers of the *deactivation* action.

Providers/suppliers who Medicare billing privileges are deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

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Application Fees

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $560.00 for Calendar Year (CY) 2017. CMS has defined "institutional provider" to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2017 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to *https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do* and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with your uploaded documents on PECOS or mail it to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

SUMMARY:

- CMS will post the revalidation due dates for the upcoming revalidation cycle on *http://go.cms.gov/MedicareRevalidation* for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier's billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
- If the provider/supplier has not billed Medicare for the previous 12 consecutive months, the MAC will deactivate their Medicare billing privileges.
- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.
- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional information

To find out whether a provider/supplier has been mailed a revalidation notice go to *http://go.cms.gov/MedicareRevalidation* on the CMS website.

A sample revalidation letter is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certi ication/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf on the CMS website.* A revalidation checklist is available at *http://www.cms. gov/Medicare/Provider-Enrollment-and-Certi ication/MedicareProviderSupEnroll/Revalidations.html* on the CMS website.

For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf* on the CMS website.

For more information about the application fee payment process, refer to MLN Matters Article SE1130, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf* on the CMS website.

The MLN fact sheet titled "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf* on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to *https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin* to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment webpage at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*.

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Gender dysphoria and gender reassignment surgery

Provider types affected

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

What you need to know

This article is based on change request (CR) 9981, which informs MACs that coverage determinations for gender reassignment surgery will continue to be made by the local MACs on a case-by-case basis. Make sure that your billing staffs are aware of these changes.

Background

On August 30, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final decision memorandum (DM) on gender reassignment surgery for gender dysphoria. Importantly, the DM did not create or change existing policy – CMS did not issue a national coverage determination (NCD).

The purpose of this CR is to include an explanatory paragraph about gender reassignment surgery in the *Medicare NCD Manual* at Chapter 1, Part 2, Section 140.9. This is in response to public inquires to have information about gender reassignment surgery among Medicare coverage information.

Policy: Effective for claims with dates of service on or after August 30, 2016, coverage determinations for gender reassignment surgery, under section 1862(a)(1)(A) of the Social Security Act and any other relevant statutory requirements, will continue to be made by the local Medicare administrative contractors (MACs) on a case-by-case basis.

Additional information

The official instruction, CR 9981, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R194NCD.pdf*.

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

Document history

Date	Description
March 6, 2017	Article released

MLN Matters® Number: MM9981
Related Change Request (CR) #: CR 9981
Related CR Release Date: March 3, 2017
Effective Date: August 30, 2016
Related CR Transmittal #: R194NCD
Implementation Date: April 4, 2017

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If you have questions, contact your MAC. Medicare provider enrollment contact information for each State can be found at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf*.

Additional information

Date of Change	Description
March 15, 2017	The updated article revised the table on page 6 and added additional information after that table.
February 22, 2016	Initial article released

MLN Matters® Number: SE1605 *Revised*
Related Change Request (CR) #: CR N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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.

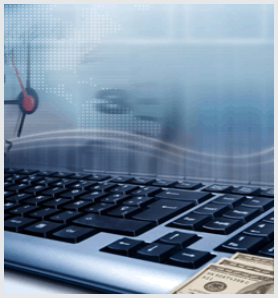
Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

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*.



Clarifications to LCDs

Rezum® System for use in the management of benign prostatic hypertrophy -- clarification regarding the system

On August 27, 2015, the FDA cleared for marketing the Rezum® System to relieve lower urinary tract symptoms secondary to benign prostatic hyperplasia. This procedure involves the transurethral injection of steam into the prostate. Once injected, the steam condenses to water, imparting convective energy to the tissue, causing cell death and damage. The technology uses radiofrequency (RF) to boil the water to create the steam that is injected, but does not impart radiofrequency directly to the prostate tissue.

Claims for procedures involving Rezum® should be coded as Current Procedural Terminology® (CPT®) code 53899 (Unlisted procedure, urinary system). The claim must also indicate that the Rezum® procedure was performed in Box 19 on the CMS 1500 form (or its electronic equivalent).

Claims for procedures involving Rezum® transurethral steam injection should not be coded as CPT® 53852 (Transurethral destruction of prostate tissue; by radiofrequency thermotherapy). CPT® code 53852 is intended for transurethral prostatic tissue destruction technology that imparts radiofrequency directly to the prostate tissue.

Hyaluronan or derivative, Gel-Syn (HCPCS code J7328) -- clarification of billing

The weekly dosage for Gel-Syn is 16.8 mg for the duration of three weeks/single course of treatment per knee. However, HCPCS code J7328 is currently being billed with a quantity billed (Q/B) reflecting “01680”, which is equivalent to 168 mg. To correctly bill the weekly dosage of 16.8 mg the Q/B should be billed as “00168”. Correct billing of HCPCS code J7328 will prevent a delay in the processing of providers claims.

Revisions to LCDs

Gene expression profiling panel for use in the management of breast cancer treatment -- revisions to the Part A/B LCD

LCD ID number: L33586 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for gene expression profiling panel for use in the management of breast cancer treatment was revised based on a reconsideration request to add Current Procedural Terminology® (CPT®) code 81479 [Unlisted molecular pathology procedure] for MammaPrint® with limited indications. The “Indications and Limitations of Coverage and/or Medical Necessity,” “CPT®/HCPCS Codes”, “ICD-10 Codes that Support Medical Necessity”, and “Sources of Information and Basis for Decision” sections of LCD were updated.

Effective date

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

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

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

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

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

The following services were evaluated and determined that they are not considered medically reasonable and necessary at this time based on current available published evidence (e.g., peer-reviewed medical literature, and published studies). Therefore, the following procedure codes have been added to the noncovered services local coverage determination (LCD).

- 0437T Implantation of non-biologic or synthetic implant (e.g., polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)
- 0438T Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance
- 0439T Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)
- 0440T Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve
- 0441T Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve
- 0442T Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial plexus, pudendal nerve)
- 0443T Real time spectral analysis of prostate tissue by fluorescence spectroscopy, including imaging guidance (List separately in addition to code for primary procedure)
- 0444T Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral
- 0445T Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral
- L8699+ Prosthetic implant, not otherwise specified (when used for hydrogel application of a spacer to increase the distance between the prostate and anterior rectal wall)

Additionally, CPT® code 84999+ [Cancer Type ID], was removed from the unlisted procedure codes Part A and Part B.

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the quality of the evidence per the Program Integrity Manual.

When addressing the articles and related information in the public domain, the jurisdiction N (JN) Medicare administrative contractor (MAC) reached the determination that available evidence was of moderate to low quality, consisting of small case series, retrospective studies, and review articles reporting limited safety and efficacy data for these procedures. Due to the unavailability of high quality evidence, the JN MAC concluded that there is insufficient scientific evidence to support these procedures, and therefore they are not considered reasonable and necessary under Section 1862(a)(1)(a) of the Social Security Act.

Any denied claim would have Medicare appeal rights. The second level of appeal (qualified independent contractor) requires review by a clinician to uphold any denial. Providers should submit for review all the relevant medical documentation and case specific information of merit and/ or new information in the public domain.

An interested stakeholder can request a reconsideration of an LCD after the draft is finalized, the notice period has ended, and the draft becomes active. In the case of the noncovered services LCD, the stakeholder may request the list of the articles and related information in the public domain that were considered by the medical policy department in making the noncoverage decision. If the stakeholder has new information based on the evaluation of the list of articles and related information, an LCD reconsideration request can be initiated. It is the responsibility of the interested stakeholder to request the evidentiary list from the contractor and to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the website.

Effective date

The LCD revision for the addition of CPT codes 0437T, 0438T/L8699, 0439T, 0440T - 0442T, 0443T and 0444T - 0445T and is effective for services rendered **on or after May 1, 2017.**

The LCD revision for the removal of CPT code 84999+ [Cancer Type ID], is effective for claims processed **on or after March 27, 2017,** for dates of service **on or after January 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, please *click here*.

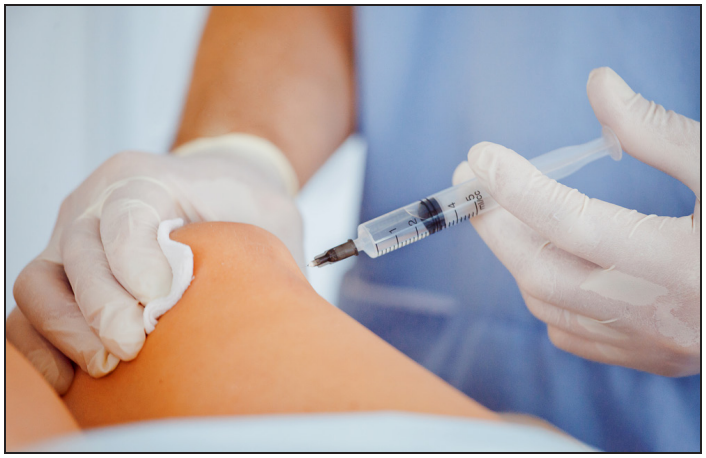
Viscosupplementation therapy for knee -- revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for viscosupplementation therapy for knee was revised based on a reconsideration request to correct the dosage and duration of treatment for GenVisc 850®, per the Food and Drug Administration (FDA) guidelines. The "Weekly Dosage/Injections per week" column was revised to read "25 mg/1", the "Total Dosage" column was revised to read "75 to 125 mg", and the "Duration of Treatment" column was revised to read 3 to 5 weeks/single course of treatment per knee" in the "Utilization Guidelines" section of the LCD.

Effective date

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



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

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

Controlled substance monitoring and drugs of abuse testing -- revision to the Part A and Part B LCD

LCD ID number: L36393 (Florida/Puerto Rico/ U.S. Virgin Islands)

Based on the 2017 HCPCS Update (CR9752), HCPCS codes G0477-G0479 were deleted and replaced with CPT® codes 80305-80307 in the "CPT®/HCPCS Codes" section of the local coverage determination (LCD) for controlled substance monitoring and drugs of abuse testing.

Effective date

This LCD revision is effective for claims processed **on or after March 9, 2017**, for services rendered **on or after January 1, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Paclitaxel (Taxol®) -- revision to the Part A and Part B LCD

LCD ID number: L33730 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for paclitaxel (Taxol®) was revised based on a reconsideration request to add malignant neoplasm of vulva to the list of off-label indications within the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, ICD-10-CM diagnosis codes C51.8 and C51.9 were added 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 March 9, 2017**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

Note: To review active, future and retired LCDs, please

ICD-10 coding revisions to national coverage determinations

Provider types affected

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

What you need to know

Change request (CR) 9982 is the 11th maintenance update of ICD-10 conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, CR 8691, CR 9087, CR 9252, CR 9540, CR 9631, CR 9751, and CR 9861; while others are the result of revisions required to other NCD-related CRs released separately. *MLN Matters*® articles MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, MM9540, MM9631, MM9751, and MM9861 contain information pertaining to these CRs.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete general equivalence mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies.

In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. There may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable, as of October 1, 2015.

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed.

CR 9982 makes coding and clarifying adjustments to the following NCDs:

- NCD20.31 - Intensive Cardiac Rehabilitation (ICR)
- NCD20.31.1 - ICR Pritkin Program
- NCD20.31.2 - ICR Ornish Program
- NCD20.31.3 - ICR Benson-Henry Program
- NCD20.34 - Left Atrial Appendage Closure
- NCD190.3 - Cytogenetic Studies
- NCD260.3.1 - Islet Cell Transplants in Clinical Trials
- NCD270.1 - Electrical Stimulation & Electromagnetic Therapy for Treatment of Wounds
- NCD220.4 – Mammograms

The spreadsheets for the above NCDs are available at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9982.zip*.

Please remember that coding and payment areas of the Medicare program are separate and distinct from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services (CMS) and are not intended to change the original intent of the NCD.

The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate. MACs will complete all tasks that involve updates to local system edits/tables associated with the attached NCDs in this CR.

MACs will use default CAQH CORE messages where appropriate:

- RARC N386 with CARC 50, 96, and/or 119. See latest CAQH CORE update at *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

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

- Group code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed ABN is on file).
- Group code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file). For modifier GZ, use CARC 50 and MSN 8.81 per instructions in CR 7228/TR 2148 available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2148CP.pdf*.

Your MAC will not search their files to adjust previously processed claims but will adjust any claims that you bring to their attention if appropriate to do so.

Additional information

The official instruction, CR 9982, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1798OTN.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/*

See **ICD-10** on page 31

Healthcare provider taxonomy codes April 2017 update

Provider types affected

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

Provider action needed

Change request (CR) 9869 instructs macs to obtain the most recent healthcare provider taxonomy code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use.
2. Terminated codes are not approved for use after a specific date.
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR 9869 implements the NUCC HPTC code set that is effective on April 1, 2017, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

MACs will implement the April 2017 HPTC update as soon as they can after April 1, 2017, but not beyond July 3, 2017. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at *http://www.wpc-edi.com/codes*.

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:

- New items are green
- Modified items are orange
- Inactive items are red

Additional information

The official instruction, CR 9869, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3723CP.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: MM9869
Related Change Request (CR) #: CR 9869
Related CR Release Date: February 24, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3723CP
Implementation Date: July 3, 2017

ICD-10

from page 30

Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

MLN Matters® Number: MM9982
Related Change Request (CR) #: CR 9982
Related CR Release Date: February 17, 2017
Effective Date: July 1, 2017 (Unless otherwise noted in individual NCDs)
Related CR Transmittal #: R1798OTN
Implementation Date: March 20, 2017, for MAC edits and July 3, 2017, for Shared Systems

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

Remittance and claims adjustment reason code update

Provider types affected

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

What you need to know

Change request (CR) 9878 updates the remittance advice remark code (RARC) and claim adjustment reason code (CARC) lists. CR 9878 also calls for an update to Medicare remit easy print (MREP) and PC Print software. If you use MREP and/or PC Print software, be sure to obtain the latest version that is released on or before July 3, 2017. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that is published three times per year – around March 1, July 1, and November 1.

CR 9878 provides notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare's shared system maintainers (SSMs) have the responsibility to implement code deactivation, 1) making sure that any deactivated code is not used in original business messages, and 2) allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in CR 9878, MACs must implement on the date specified on the WPC website.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not

match the CMS release schedule. For CR 9878, MACs and SSMs must determine the changes that are included on the code list since the last code update CR (CR 9774) or its corresponding MM Article (MM9774).

Additional information

The official instruction, CR 9878, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3725CP.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: MM9878
Related Change Request (CR) #: CR 9878
Related CR Release Date: February 24, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3725CP
Implementation Date: July 3, 2017

Check the status of claim redeterminations online

Don't wait up to learn the status of your appeal. You may check on its status at your convenienve -- online, which enables providers to check the status on active redeterminations to confirm if the appeal has been received by First Coast Service Options.

Upcoming provider outreach and educational events

Medicare Te Informa 2017 Dorado

Date: April 20-21
Time: 8:00 AM-3:30 PM AST
Type of Event: Face-to-face
https://medicare.fcso.com/Medicare_te_informa/0368651.asp

E/M Services: Documenting Nursing Facility Visits (B)

Date: Tuesday, April 25
Time: 10:00-11:30 AM
Type of Event: Webcast
https://medicare.fcso.com/Events/0371066.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 February 23, 2017

MLN Connects® for February 23, 2017

View this edition as a PDF

News & Announcements

- CMS Awards Approximately $100 Million to Help Small Practices Succeed in the Quality Payment Program
- NHSN Data Submission Deadline for IRF and LTCH QRP: Extended to May 15

Provider compliance

- Reporting Changes in Ownership

Upcoming Events

- SNF VBP: Understanding Your Facility's Confidential Feedback Report Call — March 15
- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Comparative Billing Report on Physical Therapy Webinar — March 29

Medicare Learning Network® Publications & Multimedia

- Collecting Data on Sexual Orientation and Gender Identity in Health Care Settings Web-Based Training Course — New
- Audio Recordings and Transcripts from Recent Calls — New
- Medicare Outpatient Observation Notice Instructions MLN Matters Article — Revised
- Acute Care and the IPPS Web-Based Training Course — Revised

MLN Connects® for March 2, 2017

MLN Connects® for March 2, 2017

View this edition as a PDF

News & Announcements

- IRF and LTCH QRP Preview Reports Available: Review by March 30
- March is National Colorectal Cancer Awareness Month

Provider compliance

- Home Health Care: Proper Certification Required

Upcoming Events

- SNF VBP: Understanding Your Facility's Confidential Feedback Report Call — March 15
- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Home Health Quality Reporting Program Provider Training — May 3 and 4

Medicare Learning Network® Publications & Multimedia

- Critical Access Hospital Booklet — Revised
- Transitional Care Management Services Fact Sheet — Revised
- MREP Software Fact Sheet — Reminder
- HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Reminder
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder

MLN Connects® for March 9, 2017

MLN Connects® for March 9, 2017

View this edition as a PDF

News & Announcements

- Social Security Number Removal Initiative: New Details
- Clinical Laboratories: Report Lab Data through March 31
- New Release of PEPPER for Short-term Acute Care Hospitals
- Hospice Quality Reporting Program: Rerun Your Quality Measure Reports
- LTCHs: Exceptions to Moratorium on Increasing Beds
- Therapeutic Continuous Glucose Monitors Classified as Durable Medical Equipment
- Influenza Activity Continues: Are Your Patients Protected?

Provider compliance

- Chiropractic Services: High Improper Payment Rate within Medicare FFS Part B

Claims, Pricers & Codes

- April 2017 Average Sales Price Files Available

Upcoming Events

- SNF VBP: Understanding Your Facility's Confidential Feedback Report Call — March 15
- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Medicare Diabetes Prevention Program Expanded Model Webinar — March 22
- Medicare ACO Track 1+ Model Webinar — March 22
- DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act Call — March 23
- IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29
- Open Payments: Prepare to Review Reported Data Call — April 13

Medicare Learning Network® Publications & Multimedia

- Medicare Enrollment Resources Educational Tool — New
- Chronic Care Management Services Call: Audio Recording and Transcript — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Suite of Products & Resources Educational Tools — Revised
- Federally Qualified Health Center Fact Sheet — Revised
- PECOS for DMEPOS Suppliers Fact Sheet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder
- Advance Care Planning Fact Sheet — Reminder

MLN Connects® for March 16, 2017

MLN Connects® for March 16, 2017

View this edition as a PDF

News & Announcements

- Revised CMS-855O Application: Enrollment Solely to Order, Certify, or Prescribe
- Comparative Billing Report on Sudomotor Function Testing in April
- IRF and LTCH QRP Preview Reports Available: Review by March 30
- Improve Health during National Nutrition Month®

Provider compliance

- Inpatient Skilled Nursing Facility Denials

Claims, Pricers & Codes

- Chronic Care Management Payment Correction for RHCs and FQHCs

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Medicare ACO Track 1+ Model Webinar — March 22
- DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act Call — March 23
- IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29
- Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call — April 6
- Open Payments: Prepare to Review Reported Data Call — April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
- Comparative Billing Report Webinar on Sudomotor-Function Testing — May 10

Medicare Learning Network® Publications & Multimedia

- Rural Health Clinic Fact Sheet — Revised

Phone numbers

Customer service

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

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

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

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

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

The SPOT help desk

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

Addresses

Claims

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

Redeterminations

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

Redetermination of overpayments

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

Reconsiderations

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

General inquiries

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

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

Provider enrollment

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

Medical policy

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

Medicare secondary payer

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

Electronic data interchange (EDI)

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

Overpayments

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

Medicare Education and Outreach

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

Fraud and abuse

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

Freedom of Information Act requests

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

Overnight mail and/or special courier service

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

Websites

Provider

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

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

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

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

Beneficiaries

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

Phone numbers

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

Education event registration hotline
904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)
888-670-0940

Electronic funds transfers (EFT) (CMS-588)
866-454-9007
877-660-1759 (TTY)

Fax number (for general inquiries)
904-361-0696

Interactive voice response (IVR) system
877-847-4992

Provider enrollment
888-845-8614
877-660-1759 (TTY)

The SPOT help desk
855-416-4199
Email: *FCSOSPOTHelp@FCSO.com*

Addresses

Claims
Medicare Part B Claims
P.O. Box 45098
Jacksonville, FL 32232-5098

Redeterminations
Medicare Part B Redetermination
P.O. Box 45024
Jacksonville, FL 32232-5024

Redetermination of overpayments
First Coast Service Options Inc.
P.O Box 45091
Jacksonville, FL 32232-5091

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

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

Email: *askFloridaB@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

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

https://medicare.fcso.com

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

Centers for Medicare & Medicaid Services

https://www.cms.gov

First Coast University

http://www.fcsouniversity.com/

Beneficiaries
Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

Customer service

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
https://medicare.fcso.com

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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.

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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. **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		
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Please write legibly			Subtotal	$
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P.O. Box 406443
Atlanta, GA 30384-6443

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Provider/Office Name: _____

Phone: _____

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