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

In this issue

Screening for the human immunodeficiency virus infection

Provider type 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) 9980 informs MACs that they shall recognize the specified HCPCS codes for services related to the Screening for the human immunodeficiency virus (HIV) infection. Make sure that your billing staffs are aware of these codes.

Background

The Centers for Medicare & Medicaid Services (CMS) issued CR 9403 (transmittal 3461), effective April 13, 2015, for screening for HIV infection. The guidelines are based on strong recommendations by the U.S. Preventive Services Task Force published in April 2013. The recommendations provide guidelines for screening various age groups based on risk of infection as well as for pregnant women.

Effective for claims with dates of service on or after April 13, 2015, MACs will recognize the following Healthcare Common Procedure Coding System (HCPCS) codes for claims processed on or after October 2, 2017: G0432, G0433, and G0435. Testing frequency and other functions for these codes is the same as for those listed in CR 9403. A related *MLN Matters*® article is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9403.pdf*.

HCPCS code	Descriptor
G0432	Infectious agent antibody detection by enzyme Immune assay (EIA) technique, qualitative or Semi-quantitative, multiple-step method, HIV-1 or HIV-2, screening
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening.

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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.

Publication staff:

Marielba Cancel
Terri Drury
Maria Murdoch
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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About the Medicare B Connection

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

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

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

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

Never miss an appeals deadline again

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

Medicare Part B advance beneficiary notices

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

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

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

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

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44*.

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

HIV

from front page

HCPCS code	Descriptor
G0435	Infectious agent antibody detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening.

Billing requirements

Your MAC will calculate the next eligible date for HIV screening to include HCPCS codes G0432, G0433, and G0435 to be included with G0475 and based on effective date of April 13, 2015.

The next eligible date will be displayed on all of Medicare's common working file (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN). This includes MBD and NGD extract records.

When there is no next eligible date, the CWF provider query screens will display this information in the date field to indicate why there is not a next eligible date.

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS code G0475, G0432, G0433, or G0435 is submitted without the required HIV primary diagnosis codes of Z11.4, OR

When the incoming HUOP or HUBC claim line having the HIV screening HCPCS 80081 is submitted with one of the following secondary diagnosis codes denoting pregnancy, but the required HIV primary diagnosis code of Z11.4 is not present:

- Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34,90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93

The claim line item will be denied. In denying the line, MACs will use either:

- **Claim adjustment reason code (CARC)** 167 - This (these) diagnosis(es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. or
- **CARC 11** - This diagnosis is inconsistent with the procedure. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks code (RARC) N386** - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *https://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code** CO (contractual obligation)

Medicare will create a new consistency edit to deny when the incoming HUOP or HUBC claim line having either the HIV HCPCS codes G0475, G0432, G0433, G0435, or the CPT® HCPCS code 80081 is submitted with one of the pregnancy secondary diagnosis codes, but the sex code on the claim indicates 'male.' The secondary diagnosis codes indicating pregnancy are:

- Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93

In denying a line for this reason, MACs will use:

- **CARC 7** - The procedure/revenue code is inconsistent with the patient's gender. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Group code** CO

Medicare systems will create a consistency edit to not allow place of service (POS) other than 11 (office) or 81 (independent lab for the HIV screenings HCPCS G0475, G0432, G0433, and 'G0435' effective with dates of service on or after April 13, 2015. If a POS other than 11 or 81 is on the claim, the MAC will deny the line item, using:

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

Medicare systems will create a consistency edit to not allow type of bill (TOB) other than 12x, 13x, 14x, 22x, 23x, and 85x for the HIV screening HCPCS G0475, G0432, G0433, and G0435.

Additional information

The official instruction, CR 9980, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3778CP.pdf*.

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

Document history

Date of change	Description
June 6, 2017	Initial article released.

MLN Matters® Number: MM9980
Related Change Request (CR) #: CR 9980
Related CR Release Date: May 24, 2017
Effective Date: April 13, 2015
Related CR Transmittal #: R3778CP
Implementation Date: October 2, 2017

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Ambulance

Update to clarify ambulance locality and ALS assessment

Provider type affected

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

What you need to know

Change request (CR) 10110 which revises the *Medicare Benefit Policy Manual* (Chapter 10, Sections 10.3.5 and 30.1.1) to clarify the definitions for locality and ground ambulance services for advanced life support (ALS) assessment. The term "locality" with respect to ambulance service means the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services. Your MACs have the discretion to define "locality" in their service areas.

Background

CR 10110 provides clarifications of the definitions for locality and ground ambulance services for ALS assessment and it revises the *Medicare Benefit Policy Manual* to clarify that:

- MACs have the discretion to define "locality" in their service areas.
- If an ALS assessment is performed, the services will be covered at the ALS emergency level if medically necessary and all other coverage requirements are met.

The Centers for Medicare & Medicaid Services (CMS) defines the term "locality" (with respect to ambulance service) as the service area surrounding the institution to which individuals normally travel (or are expected to travel) to receive hospital or skilled nursing services.

Example: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community and both regularly provide hospital services to the community's residents. The community is within the "locality" of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

ALS assessment is defined in *42 CFR 414.605* as an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment.

Note that an ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

In the *Medicare Benefit Policy Manual* (Chapter 10, Section 30.1.1), CMS states that in the case of an appropriately dispatched ALS emergency service, if the ALS crew completes an ALS assessment, then the services provided by the ambulance transportation service provider or supplier may be covered at the ALS emergency level. This is regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary.

Additional information

The official instruction, CR 10110, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2017Downloads/R236BP.pdf*.

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

Document history

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

MLN Matters® Number: MM10110
Article Release Date: June 16, 2017
Related CR Transmittal Number: R236BP
Related Change Request (CR) Number: 10110
Effective Date: September 18, 2017
Implementation Date: September 18, 2017

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Ambulatory Surgical Center

July 2017 update of the ASC payment system

Provider type affected

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

What you need to know

Change request (CR) 10138 informs MACs about changes to the ASC payment center and billing instructions for various payment policies implemented in the July 2017 ASC payment system update. The CR also includes HCPCS updates. Make sure your billing staffs are aware of these changes.

Background

This article notifies the MACs about updates to the ASC payment center and billing instructions for various payment policies implemented in the July 2017 ASC payment system update, as well as HCPCS changes.

CR 10138 also includes 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). CR 10138 includes 2017 ASC payment rates for covered surgical and ancillary services (ASCFS file).

1. Category III CPT® code, effective July 1, 2017

The American Medical Association (AMA) releases Category III *Current Procedural Terminology* (CPT®) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

For the July 2017 update, the Centers for Medicare & Medicaid Services (CMS) is implementing one (1) Category III CPT® code that AMA released in January 2017 for implementation on July 1, 2017. The ASC payment rate and ASC payment indicator (ASC PI) for this code is listed in Table 1.

Table 1 — Category III CPT® code, effective July 1, 2017

CPT® code	Short descriptor	Long descriptor	July 2017 ASC PI
0474T	Insj aqueous drg dev io rsvr	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space	J8

2. New separately payable procedure codes

Effective July 1, 2017, three new HCPCS codes (C9745, C9746, and C9747) have been created. These codes, along with their descriptors and ASC PI, are listed in Table 2.

Table 2 — New separately payable procedure codes, effective July 1, 2017

HCPCS code	Short descriptor	Long descriptor	July 2017 ASC PI
C9745	Nasal endo eustachian tube	Nasal endoscopy, surgical; balloon dilation of eustachian tube	J8
C9746	Trans imp balloon cont	Transperineal implantation of permanent adjustable balloon continence device, with cystourethroscopy, when performed and/or fluoroscopy, when performed	J8
C9747	Ablation, HIFU, prostate	Ablation of prostate, transrectal, high intensity focused ultrasound (HIFU), including imaging guidance	G2

3. Drugs, biologicals, and radiopharmaceuticals

a. ASC drugs and biologicals with OPPS pass-through status, effective July 1, 2017

For 2017, two 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 listed in Table 3.

Table 3 — ASC drugs and biologicals with OPPS pass-through status, effective July 1, 2017

HCPCS code	Short descriptor	Long descriptor	ASC PI
C9489	Injection, nusinersen	Injection, nusinersen, 0.1 mg	K2
C9490	Injection, bezlotoxumab	Injection, bezlotoxumab, 10 mg	K2

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b. Drugs and biologicals with payments based on average sales price (ASP), effective July 1, 2017

For 2017, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals continues to be made at a single rate of ASP + six 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 + six 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 July 1, 2017, and drug price restatements are in the July 2017 ASC Addendum BB, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ASCPayment/11_Addenda_Updates.html*.

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

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

d. New drug HCPCS codes effective July 1, 2017

Effective July 1, 2017, one new HCPCS code has been created for reporting drugs and biologicals in the ASC payment system, where there have not previously been specific codes available. This new code is listed in Table 4.

Table 4 — New drug HCPCS codes, effective July 1, 2017

HCPCS code	Short descriptor	Long descriptor	ASC PI
Q9986	Inj, Makena	Injection, hydroxyprogesterone caproate (Makena), 10 mg	K2

e. Change to ASC payment indicator for CPT® code 90682

The influenza vaccine associated with CPT® code 90682 (Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use) is approved for use in the 2017-2018 flu season (see *MLN Matters*® article MM9876 at *https://www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork-MLN/MLNMattersArticles/Downloads/MM9876.pdf*). CPT® code 90682 was added to the January 2017 ASCFS with an effective date of January 1, 2017, and assigned an ASC PI of "L1" (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made). Because this code is not a payable code until the start of the 2017 flu season, the payment indicator will be retroactively corrected from ASC PI=L1 to ASC PI=Y5 (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made) effective January 1, 2017, through June 30, 2017. Effective July 1, 2017, CPT® code 90682 is assigned SI=L1. ASCs are reminded that ordinarily packaged codes are not billed in the ASC payment system. This change is described in Table 5.

Table 5 – Change to ASC payment indicator for CPT® code 90682

CPT® code	Descriptor		ASC PI	
	Short	Long		
90682	Riv4 vacc recombinant dna im	Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use	Y5	January 1–June 30, 2017
90682	Riv4 vacc recombinant dna im	Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free, for intramuscular use	L1	July 1, 2017

f. Revised status indicator for HCPCS code J1725

For the July 2017 update, the HCPCS workgroup inactivated HCPCS code J1725 for Medicare reporting and replaced it with HCPCS code Q9986 (see Table 4 for Q9986 descriptors and ASC PI). Therefore, effective July 1, 2017, the ASC PI for HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) will change from ASC PI=K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure

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on ASC list; payment based on OPPS rate) to ASC PI= Y5 (Nonsurgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made). Table 6 (bottom of page) describes the status indicator change and effective date for HCPCS code J1725. The payment rate for HCPCS codes Q9986 is included in the July 2017 ASC Addendum BB, available at *https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/ASCPayment/11_Addenda_Updates.html*.

g. Other changes to 2017 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

Effective July 1, 2017, HCPCS code Q9989 (Ustekinumab, for Intravenous Injection, 1 mg) will replace HCPCS code C9487 (Ustekinumab, for intravenous injection, 1 mg). The payment indicator will remain K2, "Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate." The HCPCS code change and effective date are described in Table 7 (bottom of page).

4. Coverage determinations

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

Additional information

The official instruction, CR 10138, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3792CP.pdf*.

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

Document history

Date of change	Description
June 9, 2017	The article was revised due to the release of an updated CR that corrected an error to the ASC payment indicator for C9747 in Table 2 (changed from J8 to G2).
June 2, 2017	Initial article released.

MLN Matters® Number: MM10138
Related Change Request (CR) Number: CR 10138
Related CR Release Date: June 9, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3792CP
Implementation Date: July 3, 2017

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Table 6 – Revised status indicator for HCPCS code J1725

HCPCS	Short descriptor	Long descriptor	ASC PI	Effective date	Termination date
J1725	Hydroxyprogesterone caproate	Injection hydroxyprogesterone caproate, 1 mg	K2	01/01/2012	06/30/2017
J1725	Hydroxyprogesterone caproate	Injection hydroxyprogesterone caproate, 1 mg	Y5	07/01/2017	

Table 7 – Other changes to 2017 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals, effective July 1, 2017

HCPCS code	Short descriptor	Long descriptor	ASC PI	Effective date	Termination date
C9487	Ustekinumab IV inj, 1 mg	Ustekinumab, for Intravenous Injection, 1 mg	K2	04/01/2017	06/30/2017
Q9989	Ustekinumab IV Inj, 1 mg	Ustekinumab, for Intravenous Injection, 1 mg	K2	07/01/2017	

Chiropractic Services

Improper chiropractic billing for therapy

Medicare audit reviews have found that a significant portion of chiropractic service claims have been paid inappropriately due to insufficient documentation or lack of medical necessity. These widespread errors contribute to First Coast Service Options' (First Coast) payment error rate, as measured by the comprehensive error rate testing (CERT) program.

Correct claim payment depends on providers complying with Medicare requirements for coverage, coding, and documentation of services. This article was created to educate providers on the most common errors and how to avoid them to comply with Medicare regulations.

Summary of payment errors

The most common errors noted by Medicare auditors of chiropractic service claims are:

- Insufficient or missing documentation such as missing signatures or missing date of service in the medical record.
- Documentation that does not substantiate that all procedure(s) reported were performed such as:
  - No documentation or insufficient documentation that all spinal levels of manipulation reported has been performed.
  - No documentation that each manipulation reported was performed on a relevant symptomatic spine level.
  - Insufficient or absent documentation that all procedures or services were medically reasonable and necessary.
  - Required elements of the history and examination were absent.
  - Treatment plan was absent or insufficient.
  - Lack of medical necessity for treatment furnished as "maintenance" therapy.

Documentation requirements, limitations of coverage, and medical necessity

Coverage of chiropractic services is specifically limited to treatment by means of manual manipulation (e.g., by use of the hands) of the spine to correct a subluxation. No other diagnostic or therapeutic service furnished by a chiropractor, or under the chiropractor's order, is covered. The record is an integral indicator of the medical necessity for the service provided during an encounter. Providers must ensure that documentation within each encounter reflects the level of service actually provided as well as meets payer requirements for appropriate reimbursement.

First Coast has developed a *chiropractic services documentation checklist* file to assist providers in ensuring these requirements are met. Be aware, however, that this checklist is for providers' internal use and its completion does not constitute a guarantee of coverage.

Additional guidance can be found in the First Coast local coverage determination (LCD) ID L36617 -- Chiropractic Services.

Source: The Centers for Medicare & Medicaid Services (CMS) internet-only manual (IOM) *Pub. 100-02, Chapter 15, Section 30.5 and Section 240*; CMS IOM *Pub. 100-04, Chapter 12, Section 220*; LCD ID L36617

Social Security Number Removal Initiative (SSNRI)

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires the Centers for Medicare & Medicaid Services (CMS) to remove Social Security numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

Distribution of new Medicare cards will begin April, 2018. Resources are available to prepare you for this change at *https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp*.

Drugs & Biologicals

July 2017 drug and biological code changes

Provider type 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

The Healthcare Common Procedure Coding System (HCPCS) code set is updated on a quarterly basis. Change request (CR) 10107 informs MACs of updating specific drug/biological HCPCS codes. Beginning July 1, 2017, the HCPCS file will include the following new codes:

- Q9984:
  - Short description: Kyleena
  - Long description: Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg
  - Type of service (TOS) code 9
- Q9985
  - Short description: Inj, hydroxyprogesterone, NOS
  - Long description: Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
  - TOS code 1, P
- Q9986
  - Short description: Inj, Makena
  - Long description: Injection, hydroxyprogesterone caproate (Makena), 10 mg
  - TOS code 1, P
- Q9988
  - Short description: Platelets, pathogen reduced
  - Long description: Platelets, pathogen reduced, each unit
  - TOS code 9
- Q9989
  - Short description: Ustekinumab IV Inj, 1 mg
  - Long description: Ustekinumab, for Intravenous Injection, 1 mg
  - TOS code 1, P

Also, beginning on July 1, 2017, HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) is no longer payable for Medicare.

Make sure your billing staffs are aware of these changes.

Additional information

The official instruction, CR 10107, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3776CP.pdf*.

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

Document history

Date of change	Description
May 18, 2017	Initial article released.

MLN Matters® Number: MM10107
Article Release Date: May 18, 2017
Related CR Transmittal Number: R3776CP
Related Change Request (CR) Number: 10107
Effective Date: July 1, 2017
Implementation Date: July 3, 2017

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Learn the secrets to billing Medicare correctly

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

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

Durable Medical Equipment

Scheduled end of the intravenous immune globulin demonstration

Provider type affected

This *MLN Matters*® article is intended for suppliers submitting claims to durable medical equipment Medicare administrative contractors (DME MACs) for intravenous immune globulin (IVIG) drugs and services provided to beneficiaries under the Medicare IVIG demonstration. The article is also intended for physicians who may treat patients with primary immune deficiency syndrome that use IVIG.

Provider action needed

Stop – impact to you

This article is a reminder of the scheduled end date for the IVIG demonstration.

Caution – what you need to know

The IVIG demonstration is a three-year demonstration that is scheduled to end September 30, 2017. Since the demonstration ends September 30, 2017, no payment will be made for the demonstration services (Q2052- IVIG demonstration, services/supplies) rendered after that date. Claims submitted after that date for dates of service on/before September 30, 2017, will continue to be processed in accordance with the IVIG demonstration guidelines. Please note that traditional Medicare fee for service will continue to pay for IVIG in the home but, once the demonstration ends, will no longer pay for the services and supplies to administer the drug unless the beneficiary is receiving covered Medicare home health services. Medicare will be notifying beneficiaries enrolled in the demonstration about the ending of payment for Q2052 as the ending of the demonstration may result in beneficiaries making alternative arrangements to receive their IVIG.

Since the demonstration ends September 30, the last date that beneficiaries can submit an application for enrollment in the demonstration is August 15, 2017. This application must be received by the IVIG demonstration support contractor, Noridian, by this date either via fax or mail. Approved enrollments will be effective 9/1/17, allowing for IVIG services to be provided in the last month of the demonstration. Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration.

Go – what you need to do

Make sure your billing staffs are aware of the end of the demonstration.

Background

The Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 authorized a three-year demonstration under Part B of Title XVIII of the Social Security Act to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of primary immune deficiency disease (PIDD).

Additional information

For more information about the Medicare IVIG demonstration, go to *https://innovation.cms.gov/initiatives/ivig/*. Additional information is also available on the Noridian IVIG website at *https://med.noridianmedicare.com/web/ivig*.

You may also want to review *MLN Matters*® article *MM9746*, which specifies the IVIG demonstration payment rate of $354.60 for services rendered on or after January 1, 2017, through September 30, 2017, for code Q2052 (services, supplies, and accessories used in the home under the Medicare IVIG demonstration).

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*. For questions specific to the IVIG demonstration, you may want to contact Noridian at 1-844-625-6284, Monday-Friday 8:30 a.m. – 4 p.m. CT.

Document history

Date of change	Description
May 30, 2017	Initial article released

MLN Matters® Number: SE17008
Article Release Date: May 30, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: September 30, 2017
Implementation Date: N/A

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Two new 'K' codes for therapeutic continuous glucose monitors

***Note**: This article was revised May 18, 2017, to reflect the revised change request (CR) 10013 issued May 18. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same. This information was previously published in the May 2017 Medicare B Connection, page 9.*

Provider type affected

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

What you need to know

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

Background

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

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

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

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

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

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

Additional information

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

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

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

Document history

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

MLN Matters® Number: MM10013 *Revised*
Related CR Release Date: May 18, 2017
Related CR Transmittal Number: R3775CP
Related Change Request (CR) Number: 10013
Effective Date: July 1, 2017
Implementation Date: July 3, 2017

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Laboratory/Pathology

October changes to the laboratory national coverage determination edit software

Provider type affected

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

What you need to know

Change request (CR) 10156 informs MACs about the changes that will be included in the October 2017 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure your billing staffs are aware of these changes.

Background

CR 10156 announces the changes that will be included in the October 2017 quarterly release of the edit module for clinical diagnostic laboratory services.

CR 10156 revises several laboratory NCD code lists as follows:

- **Add** ICD-10-CM code E034, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the lipids testing (190.23A) NCD.
- **Add** ICD-10-CM code E034, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the lipids testing (190.23B) NCD.
- **Add** ICD-10-CM codes D4959 and R9349, effective 10/1/2016, to the list of ICD-10-CM codes that are covered by Medicare for the human chorionic gonadotropin (190.27) NCD.
- **Delete** (unspecified eye) ICD-10-CM codes E083219, E083299, E083319, E083399, E083419, E083499, E083519, E083529, E083539, E083549, E083559, E083599, E0837X9, E093219, E093299, E093319, E093399, E093419, E093499, E093519, E093529, E093539, E093549, E093559, E093599, E0937x9, E103219, E103299, E103319, E103399, E103419, E103499, E103519, E103529, E103539, E103549, E103559, E103599, E1037x9, E113219, E113299, E113319, E113399, E113419, E113499, E113519, E113529, E113539, E113549, E113559, E113599, E11379, E133219, E133299, E133319, E133399, E133419, E133499, E133519, E133529, E133539, E133549, E133559, E133599, and E1337x9 from the list of ICD-10-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.
- **Delete** ICD-10-CM code Z8482 from the list of ICD-10-CM codes that are covered by Medicare for the glycated hemoglobin/glycated protein (190.21) NCD.

Additional information

MACs will not search their files to either retract payment for claims already paid or retroactively pay claims, but they will adjust such claims that you bring to their attention.

The official instruction, CR 10156, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3797CP.pdf*.

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

Document history

Date of change	Description
June 21, 2017	Initial article released

MLN Matters® Number: MM10156
Related CR Release Date: June 16, 2017
Related CR Transmittal Number: R3797CP
Related Change Request (CR) Number: CR 10156
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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Preventive Services

Medicare coverage of screening for lung cancer with low dose computed tomography

***Note**: This article was revised June 12, 2017, to add a paragraph under "Counseling and shared decision-making visit" to clarify that independent diagnostic testing facilities (IDTFs) may be eligible facilities. All other information is unchanged. This information was previously published in the July 2016 Medicare B Connection, pages 15-17.*

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.

Provider action needed

Change request (CR) 9246 informs MACs that Medicare covers lung cancer screening with LDCT if all eligibility requirements listed in the national coverage determination (NCD) are met. Make sure that your billing staffs are aware of these changes.

Background

Section 1861(ddd)(1) of the *Social Security Act (the Act)* authorizes the Centers for Medicare & Medicaid Services (CMS) to add coverage of "additional preventive services" through the NCD process. The "additional preventive services" must meet all of the following criteria:

- Be reasonable and necessary for the prevention or early detection of illness or disability;
- Be recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- Be appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the evidence for lung cancer screening with low dose computed tomography (LDCT) and determined that the criteria listed above were met, enabling CMS to cover this "additional preventive service" under Medicare Part B.

CMS issued NCD 210.14 on August 21, 2015, that provides for Medicare coverage of screening for lung cancer with LDCT. Effective for claims with dates of service on and after February 5, 2015, Medicare beneficiaries must meet all of the following criteria:

- Be 55–77 years of age;
- Be asymptomatic (no signs or symptoms of lung cancer);
- Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Be a current smoker or one who has quit smoking within the last 15 years; and,
- Receive a written order for lung cancer screening with LDCT that meets the requirements described in the NCD.

Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary's medical record, and must contain the following information:

- Date of birth;
- Actual pack–year smoking history (number);
- Current smoking status, and for former smokers, the number of years since quitting smoking;
- A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and,
- The national provider identifier (NPI) of the ordering practitioner.

Counseling and shared decision-making visit

Before the first lung cancer LDCT screening occurs, the beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision-making visit that includes the following elements and is appropriately documented in the beneficiary's medical records:

- Must be furnished by a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) as defined in Section 1861(aa)(5) of the Act); and
- Must include all of the following elements:
  - Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
  - Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
  - Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;
  - Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions;

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and,

- If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

Written orders for subsequent annual LDCT screens may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (PA, NP, or CNS).

As part of the NCD, all criteria listed in the NCD must be met to include requirements for reading radiologists and radiology imaging facilities. In addition to collecting and submitting data to a CMS-approved registry, all facilities that would like to be eligible to perform the lung cancer screening, including independent diagnostic testing facilities (IDTFs), must meet all criteria stated in the decision memo for lung cancer screening with LDCT, which is available at *https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274*. Information regarding CMS-approved registries is posted at: *https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Cancer-Screening-Registries.html*.

Coinsurance and deductibles

Medicare coinsurance and Part B deductible are waived for this preventive service.

Health Care Common Procedure Coding System (HCPCS) codes

Effective for claims with dates of service on and after February 5, 2015, the following HCPCS codes are used for lung cancer screening with LDCT:

- G0296 – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)
- G0297 – Low dose CT scan (LDCT) for lung cancer screening

In addition to the HCPCS code, these services must be billed with ICD-10 diagnosis code Z87.891 (personal history of tobacco use/personal history of nicotine dependence), ICD-9 diagnosis code V15.82.

***Note**: Contractors shall apply contractor-pricing to claims containing HCPCS G0296 and G0297 with dates of service February 5, 2015, through December 31, 2015.*

Institutional billing requirements

Effective for claims with dates of service on and after February 5, 2015, providers may use the following types of bill (TOBs) when submitting claims for lung cancer screening, HCPCS codes G0296 and G0297: 12x, 13x, 22x, 23x, 71x (G0296 only), 77x (G0296 only), and 85x.

Medicare will pay for these services as follows:

- Outpatient hospital departments – TOBs 12x and 13x - based on outpatient prospective payment system (OPPS);
- Skilled nursing facilities (SNFs) – TOBs 22x and 23x – based on the Medicare physician fee schedule (MPFS);
- Critical access hospitals (CAHs) - TOB 85x – based on reasonable cost;
- CAH Method II – TOB 85x with revenue code 096x, 097x, or 098x based on the lesser of the actual charge or the MPFS (115 percent of the lesser of the fee schedule amount and submitted charge) for HCPCS G0296 only;
- Rural health clinics (RHCs) - TOB 71x - based on the all-inclusive rate for HCPCS G0296 only; and
- Federally qualified health centers (FQHCs) – TOB 77x - based on the PPS rate for HCPCS G0296 only.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

Claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes

MACs will use the following CARCs, RARCs, and group codes when denying payment for LDCT lung cancer screening, HCPCS G0296 and G0297:

Submitted on a TOB other than 12x, 13x, 22x, 23x, 71x, 77x, or 85x:

- CARC 170 - Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N95 – This provider type/provider specialty may not bill this service.
- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

For TOBs 71x and 77x when HCPCS G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71x TOBs):

- CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

  Note: 77x TOBs will be processed through the integrated outpatient code editor under the current process.
- Group code CO assigning financial liability to the provider.

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Where a previous HCPCS G0297 is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening):

- CARC 119 – Benefit maximum for this time period or occurrence has been reached.
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered (line-level):

- CARC 6: "The procedure/revenue code is inconsistent with the patient's age. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- 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).

Note: For modifier GZ, MACs will use CARC 50.

Because the claim line was not billed with ICD-10 diagnosis Z87.891:

- CARC 167 – This (these) diagnosis(es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code: CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Additional information

The official instruction, CR 9246, consists of two transmittals:

1. Transmittal R3374CP, which updates the *Medicare Claims Processing Manual*; and
2. Transmittal R185NCD, which updates the *Medicare NCD Manual*.

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

Document history

Date of change	Description
June 12, 2017	The article was revised June 9, 2017, to include a paragraph under *Counseling and shared decision-making visit* to clarify that independent diagnostic testing facilities (IDTFs) may be eligible facilities.
June 24, 2016	The article was revised to add a link to a related article *MM9540*. That article provides an ICD-10 code that has been added for lung cancer screening with low dose computed tomography (LDCT).
November 16, 2015	Initial article posted.

MLN Matters® Number: MM9246 *Revised*
Related Change Request (CR) #: 9246
Related CR Release Date: October 15, 2015
Effective Date: February 5, 2015
Related CR Transmittal #: R3374CP and R185NCD
Implementation Date: January 4, 2016

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Screening for hepatitis B virus infection

***Note**: This article was revised on June 9, 2017, to reflect an updated change request (CR) that changed the implementation date from January 1, 2018, to January 2, 2018. All other information is unchanged. This information was previously published in the May 2017 Medicare B Connection, pages 16-20.*

Provider types affected

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

Provider Action Needed

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

Background

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

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

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

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

1. Asymptomatic, non-pregnant adolescents and adults at high risk for HBV infection. "High risk" is defined as persons born in countries and regions with a high prevalence of HBV infection (that is, ≥ 2%), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥ 8%), HIV positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection. In addition, CMS has determined that repeated screening would be appropriate annually for beneficiaries with continued high risk persons. Testing is covered annually only for persons who have continued high risk (men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection) who have not received hepatitis B vaccination.
2. A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative hepatitis B surface antigen (HBsAg) test results.

For the purposes of CR 9859:

- The determination of 'high risk for HBV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

A primary care setting is defined by the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, skilled nursing facilities, inpatient rehabilitation facilities, clinics providing a limited focus of health care services, and hospice are examples of settings not considered primary care settings under this definition.

Key points of CR 9859

Applicable Healthcare Common Procedure Coding System (HCPCS) Code

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

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

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Types of bill (TOB) for institutional claims

Effective for claims with dates of service on or after September 28, 2016, you should use the following TOBs when submitting claims with G0499, 87340, 87341, 86704, or 86706 for HBV screening:

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

Professional billing requirements

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

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

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

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

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

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

Diagnosis code reporting requirements

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

- Z11.59 - Encounter for screening for other viral disease
- Z72.89 - Other Problems related to life style.

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

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

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

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

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

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

Code	Description
Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester

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

Claim/service denial

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

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

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

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

- CARC 119 - "Benefit maximum for this time period or occurrence has been reached."
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 with or without GA modifier or a claim –line is received with a GA modifier indicating a signed ABN is on file).).
- Group code CO (contractual obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

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

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

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

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

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

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

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

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

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

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

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

- CARC 119 - "Benefit maximum for this time period or occurrence has been reached."
- RARC N362 - "The number of days or units of service exceeds our acceptable maximum."
- RARC N386 - "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group code CO (contractual obligation) - Assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

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

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

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

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

Additional notes

- HCPCS code G0499 will appear in the January 1, 2018, clinical laboratory fee schedule (CLFS), in the January 1, 2017, integrated outpatient code editor (IOCE), and in the January 1, 2017, Medicare physician fee schedule (MPFS) with indicator 'X'. HCPCS code G0499 will be effective retroactive to September 28, 2016, in the IOCE.
- Your MAC will not search for claims containing HCPCS G0499 with dates of service on or after September 28, 2016, but may adjust claims that you bring to their attention.
- You should be aware that the revision to the *Medicare National Coverage Determinations Manual* is a

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Surgery

Percutaneous image-guided lumbar decompression for lumbar spinal stenosis

Provider type affected

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

Provider action needed

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

Background

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

Section 1862(a)(1)(E) of the Social Security Act (the Act) authorizes coverage for PILD for beneficiaries with LSS under CED. On January 9, 2014, CMS posted its first NCD (150.13) covering PILD for beneficiaries with LSS when provided in a RCT meeting certain conditions under CED. Clinical studies must be designed using current validated

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national coverage determination (NCD). NCDs are binding on all carriers, fiscal intermediaries, contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs) (see 42 CFR Section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See Section 1869(f)(1)(A)(i) of the Social Security Act.)

- MACs will apply contractor pricing to claim lines with G0499 with dates of service September 28, 2016, through December 31, 2017.
- Deductible and coinsurance do not apply to G0499.

Additional information

The official instruction, CR 9859, was issued to your MAC via two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2017Downloads/R3793CP.pdf*. The second transmittal updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2017Downloads/R197NCD.pdf*.

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

Document history

Date	Description
June 9, 2017	The article was revised to reflect an updated CR that changed the implementation date from January 1, 2018, to January 2, 2018.
May 4, 2017	Initial article released.

MLN Matters® Number: MM9859 *Revised*
Related Change Request (CR) #: CR 9859
Related CR Release Date: June 9, 2017
Effective Date: September 28, 2016
Related CR Transmittal #: R3793CP and R197NCD
Implementation Date: January 2, 2018

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and reliable measurement instruments and clinically appropriate comparator treatments for patients randomized to the non-PILD group.

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

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

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

Additional information

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

The official instruction, CR 10089, issued to your MAC regarding this change consists of two transmittals. The first modifies the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3787CP.pdf*. The second updates the NCD manual and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R196NCD.pdf*. The revised sections of both manuals are attached to their respective transmittals.

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

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

Document history

Date of change	Description
June 5, 2017	Initial article released.

MLN Matters® Number: MM10089
Related Change Request (CR) Number: 10089
Related CR Release Date: May 26, 2017
Effective Date: December 7, 2016
Related CR Transmittal Number: R3787CP
Implementation Date: June 27, 2017 and R196NCD

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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.

General Coverage

ICD-10 coding revisions to national coverage determinations

Provider type affected

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

Provider action needed

Change request (CR) 10086 constitutes a maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please make sure your billing staffs are aware of these changes.

Background

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

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

CR 10086 makes coding and clarifying adjustments to the following NCDs:

- NCD20.29 - Hyperbaric oxygen (HBO)
- NCD40.7 - Outpatient intravenous insulin therapy
- NCD80.2 - Photodynamic therapy
- NCD80.2.1 - Ocular photodynamic therapy
- NCD80.3 - Photosensitive drugs
- NCD80.3.1 - Verteporfin
- NCD80.11 - Vitrectomy
- NCD100.1 - Bariatric surgery
- NCD110.4 - Extracorporeal photopheresis
- NCD110.23 - Stem cell transplantation
- NCD190.3 - Cytogenetic studies
- NCD190.11 - Home prothrombin time/international normalized ratio (PT/INR)
- NCD210.13 - Screening for hepatitis C virus
- NCD220.4 - Mammograms
- NCD220.6.17 - PET for solid tumors
- NCD270.1 - Electrical stimulation electromagnetic therapy for treatment of wounds
- NCD20.31, 20.31.1, 20.31.2, 20.31.3 - Intensive cardiac rehabilitation

The NCD spreadsheets included with CR 10086 are available at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10086.zip*.

Additional information

The official instruction, CR 10086, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1854OTN.pdf*.

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

Document history

Date of change	Description
June 13, 2017	Initial article released.

MLN Matters® Number: MM10086
Related CR Release Date: May 26, 2017
Related CR Transmittal Number: R1854OTN
Related Change Request (CR) Number: 10086
Effective Date: October 1, 2017
Implementation Date: October 2, 2017, shared system edits, July 14, 2017, local edits

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Remittance advice remark code, claims adjustment reason code, Medicare Remit Easy Print and PC Print updates

Provider type 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) 100040 updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists and also instruct VIPS Medicare system (VMS) and fiscal intermediary shared system (FISS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

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, which 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 results in publication three times per year – around March 1, July 1, and November 1.

CMS provides a CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared system maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and 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 the CR, MACs must implement those updates on the date specified on the WPC website, which is at *http://wpc-edi.com/Reference/*.

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 10040, the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR 9878).

Additional information

The official instruction, CR 10040, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3780CP.pdf*.

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

Document history

Date of Change	Description
May 26, 2017	Initial article released

MLN Matters® Number: MM10040
Related CR Release Date: May 26, 2017
Related CR Transmittal Number: R3780CP
Related Change Request (CR) Number: 10040
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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

Code list for CARC, RARC, and CAGC combinations

Provider type affected

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

Provider action needed

This article is based on change request (CR) 10041 which instructs MACs and Medicare's shared system maintainers (SSMs) to update systems based on the CORE 360 uniform use of claim adjustment reason codes (CARC), remittance advice remark codes (RARC) and claim adjustment group code (CAGC) rule publication. These system updates reflect the Committee on operating rules for information exchange (CORE) code combination list for June 2017. Make sure that your billing staff is aware of these changes.

In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

Background

The Department of Health and Human Services (DHHS) adopted the Phase III CAQH CORE, EFT and ERA operating rule set that was implemented January 1, 2014, under the Patient Protection and Affordable Care Act (ACA) of 2010.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the ACA, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The ACA defines operating rules and specifies the role of operating rules in relation to the standards.

CR 10041 deals with the regular update in CAQH CORE defined code combinations per operating rule 360 - uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule.

CAQH CORE will publish the next version of the code combination list on or about June 10, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2017. This will also include updates based on market-based review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare as the industry needs them.

You can find CARC and RARC updates at *CARC/RARC News* and CAQH CORE defined code combination updates at *CAQH/CORE News*.

Note: Per ACA mandate, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE-defined business scenarios. With the four CORE-defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 10041, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3781CP.pdf*.

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

Document history

Date of Change	Description
May 26, 2017	Initial article released

MLN Matters® Number: MM10041
Related CR Release Date: May 26, 2017
Related CR Transmittal Number: R3781CP
Related Change Request (CR) Number: 10041
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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Claim status category and claim status codes update

Provider type 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) 10043 informs MACs about system changes to update, as needed, the claim status and claim status category codes used for the Accredited Standards Committee (ASC) X12 276/277 health care claim status request and response and ASC X12 277 health care claim acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the ASC X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. This recurring update notification (RUN) may be found in Chapter 31, Section 20.7.

The National Code Maintenance Committee meets at the beginning of each ASC x12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The committee has decided to allow the industry six months for implementation of newly added or changed codes.

The codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the June 2017 committee meeting will be posted on these sites on or about July 1, 2017. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 10043.

The Centers for Medicare & Medicaid Services (CMS) will issue RUNs regarding the need for future updates to these codes. When instructed, Medicare contractors must update their claims systems to ensure that the current version of these codes is used in their claim status responses. Contractor and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes.

These code changes are to be used in editing of all ASC x12 276 transactions processed on or after the date of implementation and to be reflected in the ASC x12 277 transactions issued on and after the date of implementation of this CR 10043.

Additional information

The official instruction, CR 10043, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3782CP.pdf*.

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

Document history

Date of change	Description
May 26, 2017	Initial article released

MLN Matters® Number: MM10043
Related CR Release Date: May 26, 2017
Related CR Transmittal Number: R3782CP
Related Change Request (CR) Number: 10043
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

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Medicare establishes two new MSP set-aside arrangements

Provider type affected

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

What you need to know

This article is based on CR 9893. To comply with the government accountability office (GAO) final report titled *Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans* (*GAO 12-333*), the Centers for Medicare & Medicaid Services (CMS) will establish two new set-aside processes: a liability insurance Medicare set-aside arrangement (LMSA), and a no-fault insurance Medicare set-aside arrangement (NFMSA). An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare.

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

Background

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

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

Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance." Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA or NFMSA funds. However, liability and no-fault MSP claims that do not have a Medicare set-aside arrangement (MSA) will continue to be processed under current MSP 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/R1857OTN.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/*.

Document history

Date of change	Description
June 9, 2017	The article was revised due to the release of an updated change request (CR). The CR date, transmittal number and the link to the transmittal changed.
May 10, 2017	The article was revised due to the release of an updated CR. The CR date, transmittal number and the link to the transmittal changed.
February 17, 2017	Initial article released.

See **MSP**, next page

Provider enrollment revalidation – cycle 2

***Note**: This article was revised June 15, 2017, to change the effective date of deactivations due to non-billings from five days from the date of the deactivation letter to 10 days. (See "Deactivations due to non-billing") All other information is unchanged. This information was previously published in the April 2017 Medicare B Connection, pages 17-20.*

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

Stop – impact to you

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 know

Special note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

Go – what you need to do

1. Check *https://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

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MLN Matters® Number: MM9893 *Revised*
Related Change Request (CR) #: CR 9893
Related CR Release Date: June 8, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R1857OTN
Implementation Date: October 2, 2017

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application to your MAC within six 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 *https://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 *https://go.cms.gov/MedicareRevalidation*.

  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 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 three years for DME suppliers and five years for all other providers/suppliers).

- In addition, the MAC will send a revalidation notice within two-three 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 two 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 six-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 *https://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.**

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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 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*.

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 six months prior to due date	March 30, 2017
Issue large group notifications	Approximately six 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	November 29 – December 14, 2017

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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 10 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.

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 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 two-three 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 *https://go.cms.gov/MedicareRevalidation*.

A sample revalidation letter is available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf*. A revalidation checklist is available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html*.

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

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

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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 *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf*.

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 web page at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*.

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*.

Document history

Date of change	Description
June 15, 2017	The article was revised, to change the effective date of deactivations due to non-billings from five days from the date of the deactivation letter to 10 days.

Date of change	Description
March 15, 2017	The updated article revised the table under “Revalidation timeline and example” and added additional information after that table.
February 22, 2016	Initial article released

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

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

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.

Social Security Number Removal Initiative (SSNRI)

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires the Centers for Medicare & Medicaid Services (CMS) to remove Social Security numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

Distribution of new Medicare cards will begin April, 2018. Resources are available to prepare you for this change at *https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp*.

Retired LCDs

Ocular photodynamic therapy (OPT) with verteporfin – retired Part A and Part B LCD

LCD ID number: L33705 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on data analysis review of the ocular photodynamic therapy (OPT) with verteporfin local coverage determination (LCD), it was determined that this LCD is no longer required and, therefore, is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after June 13, 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*.

Vinorelbine tartrate (Navelbine®) – retired Part A and Part B LCD

LCD ID number: L34001 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on an annual review of the vinorelbine tartrate (Navelbine®) local coverage determination (LCD) and data analysis, it was determined that this LCD is no longer required and, therefore, is being retired.

Effective date

The retirement of this LCD is effective for services rendered **on or after June 13, 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*.

New LCD

Vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases — new Part A and Part B LCD

LCD ID number: L36962 (Florida, Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) was developed because of issues identified by the program safeguards communication group (PSCG) related to Eylea® (aflibercept) injections [Healthcare Common Procedure Coding System (HCPCS) code J0178] for exudative wet macular degeneration. Providers were administering Eylea® (aflibercept) injections at a higher frequency than listed in the medication's package insert, as well as not identifying which eye (side of the body) was being treated by using the LT/RT modifiers for the intravitreal injection [*Current Procedural Terminology* (CPT®) code 67028)]. In addition, data analysis identified an increase in utilization of other vascular endothelial growth factor inhibitors, Lucentis® (ranibizumab injection) (HCPCS code J2778) and intravitreal Avastin® (bevacizumab) (HCPCS code C9257).

Due to the risk of a high dollar claim payment error and to provide guidance to the First Coast Medical Review teams during medical reviews, the LCD for vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases has been created to address the indications and limitations of coverage and/or medical necessity, HCPCS codes, ICD-10-CM diagnosis codes, documentation guidelines, and utilization guidelines for Eylea® (aflibercept), as well as incorporating existing coverage criteria for Macugen (pegaptanib sodium injection), ranibizumab (Lucentis®), and intravitreal bevacizumab (Avastin®). Additionally, coding guidelines

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Revisions to LCD

Biofeedback – revision to Part A and Part B LCD

LCD ID number: L33615 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the LCD for biofeedback was revised in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD to remove language requiring the continuous presence of the physician or qualified non-physician practitioner (NPP) and replace it with language requiring the direct supervision by the physician or NPP. The language will read as follows: The physician and/or the non-physician practitioner (NPP) must provide direct supervision during biofeedback training when the service is rendered in the physician's office. Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services (The Centers for Medicare & Medicaid Services [CMS] Internet-Only Manual [IOM], Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 60.1 - Incident to Physician's Professional Services).

In addition, CPT® codes 90875 and 90876 are nationally noncovered by Medicare. Therefore, these codes have been removed from the "CPT®/HCPCS Codes" section of the LCD.

Effective date

The LCD revision to remove language requiring continuous presence of the physician or NPP is effective for services rendered **on or after June 15, 2017**.

The LCD revision to remove CPT® codes 90875 and 90876 is effective **for claims processed on or after June 15, 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, *click here*.

Epidural – revision to the Part B LCD

LCD ID number: L33906 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an external correspondence regarding denials of *Current Procedural Terminology* (CPT®) codes 62320 and 62322 when billed in a hospital setting, the epidural local coverage determination (LCD) was revised to remove conflicting language regarding coverage of interlaminar injections. In addition, CPT® codes 62320 and 62322 were added to the "CPT®/HCPCS Codes" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after June 13, 2017**, for services rendered **on or after January 01, 2017**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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were created and attached to the LCD to provide instructions on coding and billing for the codes listed in the LCD. The current LCDs for Macugen (pegaptanib sodium injection) (L33919), ranibizumab (Lucentis®) (L33407), and intravitreal bevacizumab (Avastin®) (L33504) will be retired when the new LCD becomes effective.

Effective date

This new LCD is effective for services rendered **on or after July 24, 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*.

Multiple Part A and Part B LCDs being revised

LCD ID number: L33261, L33267, L33279, L34042, L33661, L34003, L34011, L34014, L34018, L34021, L34022, L33755, L33754, L34031, L33985, L34029 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR) 8776 the Centers for Medicare & Medicaid Services (CMS) made operational changes to billing lab tests for separate payment. Therefore, the following local coverage determinations (LCDs) were revised to remove language related to lab services and type of bill (TOB) 13x under the "CPT®/ HCPCS Codes" section of the LCD.

- Allergy Testing
- B-Type Natriuretic Peptide (BNP)
- Circulating Tumor Cell Testing
- Creatine Kinase (CK), (CPK)
- Flow Cytometry
- Hepatitis B Surface Antibody and Surface Antigen
- Ionized Calcium
- Magnesium
- Parathormone (Parathyroid Hormone)
- Sedimentation Rate, Erythrocyte
- Serum Phosphorus
- Susceptibility Studies
- Syphilis Test
- Total Calcium
- Transplantation Immune Cell Function Assay (ImmuKnow)
- Urinalysis

Effective date

These LCD revisions are effective for claims processed **on or after May 12, 2017**, for services rendered **on or after January 1, 2014**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Noncovered services – revision to 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).

- 0446T Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training
- 0447T Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision
- 0448T Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new implantable sensor, including system activation
- 0449T Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device
- 0450T Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)
- 0451T Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; complete system (counterpulsation device, vascular graft, implantable vascular hemostatic seal, mechano-electrical skin interface and subcutaneous electrodes)
- 0452T Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; aortic counterpulsation device and vascular hemostatic seal
- 0453T Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; mechano-electrical skin interface
- 0454T Insertion or replacement of a permanently implantable aortic counterpulsation ventricular assist system, endovascular approach, and programming of sensing and therapeutic parameters; subcutaneous electrode
- 0455T Removal of permanently implantable aortic counterpulsation ventricular assist system; complete system (aortic counterpulsation device, vascular hemostatic seal, mechano-electrical skin interface and electrodes)
- 0456T Removal of permanently implantable aortic counterpulsation ventricular assist system; aortic counterpulsation device and vascular hemostatic seal
- 0457T Removal of permanently implantable aortic counterpulsation ventricular assist system; mechano-electrical skin interface

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- 0458T Removal of permanently implantable aortic counterpulsation ventricular assist system; subcutaneous electrode
- 0459T Relocation of skin pocket with replacement of implanted aortic counterpulsation ventricular assist device, mechano- electrical skin interface and electrodes
- 0460T Repositioning of previously implanted aortic counterpulsation ventricular assist device; subcutaneous electrode
- 0461T Repositioning of previously implanted aortic counterpulsation ventricular assist device; aortic counterpulsation device
- 0462T Programming device evaluation (in person) with iterative adjustment of the implantable mechano-electrical skin interface and/or external driver to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable aortic counterpulsation ventricular assist system, per day
- 0463T Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable aortic counterpulsation ventricular assist system, per day
- 0464T Visual evoked potential, testing for glaucoma, with interpretation and report
- 0466T Insertion of chest wall respiratory sensor electrode or electrode array, including connection to pulse generator (list separately in addition to code for primary procedure)
- 0467T Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator
- 0468T Removal of chest wall respiratory sensor electrode or electrode array
- 64568 Incision for implantation of cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator [when specified as implantation of hypoglossal nerve stimulator]

Also, clarifying language (++Covered if meets CMS coverage with evidence development [CED] criteria) was added in the "CPT®/HCPCS Codes" section of the LCD related to procedure codes 0387T, 0388T, 0389T, 0390T and 0391T.

In addition, based on CR 8776, the following language was removed from the "CPT®/HCPCS Codes" section of the LCD: "Per CR 8572, beginning in 2014, payment for most laboratory tests (except for molecular pathology tests) will be packaged under the OPPS, therefore the clinical laboratory tests listed below, for type of bill (TOB) 13x (outpatient hospital), are packaged in this setting."

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 related to the addition of procedure codes 0446T - 0448T, 0449T - 0450T, 0451T - 0463T, 0464T, 0466T – 0468T and CPT® code 64568 is effective for services rendered **on or after July 24, 2017**.

The LCD revision related to the addition of clarifying language added for procedure codes 0387T – 0391T is effective for claims processed **on or after July 24, 2017**, for services rendered **on or after January 18, 2017**.

The LCD revision related to the removal of language referencing the packaging of lab tests for type of bill 13x is effective date for claims processed **on or after May 12, 2017**, for services rendered **on or after January 1, 2014**.

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*.

Ranibizumab (Lucentis®) – revision to Part A and Part B LCD

LCD ID number: L33407 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request, the local coverage determination (LCD) for ranibizumab (Lucentis®) was revised to add two new indications approved by the Food and Drug Administration (FDA) (Myopic Choroidal Neovascularization and Diabetic Retinopathy) to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. In addition, ICD-10-CM diagnosis codes E10.319, E10.3291-E10.3293, E10.3391-E10.3393, E10.3491-E10.3493, E10.3591-E10.3593, E11.319, E11.3291-E11.3293, E11.3391-E11.3393, E11.3491-E11.3493, E11.3591-E11.3593, E13.319, E13.3291-E13.3293, E13.3391-E13.3393, E13.3491-E13.3493, E13.3591-E13.3593, and H35.051-H35.053 were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) code J2778.

Effective date

The revision related to the addition of myopic choroidal neovascularization is effective for claims processed **on or after June 1, 2017**, for services rendered **on or after January 5, 2017**.

The revision related to the addition of diabetic retinopathy is effective for claims processed **on or after June 1, 2017**, for services rendered **on or after April 15, 2017**.

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

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

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

Vitamin D; 25 hydroxy, includes fraction(s), if performed – revision to the Part A and Part B LCD

LCD ID number: L33771 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a reconsideration request, the local coverage determination (LCD) for vitamin D; 25 hydroxy, includes fraction(s), if performed was revised to add multiple indications to the *Indications and Limitations of Coverage and/or Medical Necessity* section of the LCD, and supporting ICD-10-CM codes A15.0—A19.9, B38.1— B38.9, B39.1— B39.9, C82.00— C82.99, D80.0— D80.9, D86.0— D86.9, D89.810— D89.813, E67.8, E68, E83.59, E84.0, E84.19— E84.8, G73.7, J63.2, K50.00— K51.319, K51.50—K52.0, K74.1, K74.2, K83.8, K86.0— K86.1, K86.81— K86.89, K87, K90.81, L40.0— L40.9, M32.0— M32.9, M33.00— M33.99, M36.0, M60.80— M60.9, M79.1, M79.7, M81.6, M85.80, Q78.0, Q78.2, Z68.30-Z68.45, Z79.3, Z79.51—Z79.52, Z79.891—Z79.899, Z98.0, and Z98.84 were added to the *ICD-10 Codes that Support Medical Necessity* section of the LCD. Also, the *Sources of Information* section of the LCD was updated.

In addition, based on change request (CR) 8776 the Centers for Medicare & Medicaid Services (CMS) made operational changes to billing lab tests for separate payment. Therefore, the vitamin D; 25 hydroxy, includes fraction(s), if performed LCD was revised to remove language related to lab services and type of bill (TOB) 13x under the "CPT®/HCPCS Codes" section of the LCD.

Effective date

The LCD revision related to the addition of multiple indications is effective for services rendered **on or after June 22, 2017**.

This LCD revision related to lab services and TOB 13x is effective for claims processed **on or after May 12, 2017**, for services rendered **on or after January 1, 2014**.

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*.

Additional Information

New approach to LCD lookups

The Centers for Medicare & Medicaid Services (CMS) Medicare coverage database (MCD) offers providers more functionality, options, and enhanced timeliness than the previous tool hosted by First Coast Service Options (First Coast). The LCD lookup tool provided by First Coast was retired June 12, 2017.

Options available within the MCD will help you find local coverage determinations (LCDs) and national coverage determinations (NCDs). Previously, the First Coast LCD lookup data was refreshed weekly based on a download that was available one or two days behind the MCD. The MCD offers new local coverage information every Thursday, while national coverage information is updated in realtime.

Multiple ways to locate and view data

QUICK SEARCH – The MCD allows users to search both the NCD and LCD databases using a variety of criteria such as keyword, diagnosis/procedure, and date. Quick search is located at the top right of the MCD *overview page*. Click *ADVANCED SEARCH* to use additional filters to find exactly what you are looking for.

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

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

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

Help using the MCD

For more information about using the MCD, *click here*.

Eclipse system for the treatment of fecal incontinence in adult women– clarification regarding the device technology and correct billing

On February 12, 2015, the Food and Drug Administration (FDA) cleared for marketing the eclipse system for the treatment of fecal incontinence (FI) in adult women. The eclipse system is intended to treat FI in women 18 to 75 years old who have had four or more FI episodes in a two-week period. The device includes an inflatable balloon, which is placed in the vagina. Upon inflation, the balloon exerts pressure through the vaginal wall onto the rectal area, thereby reducing the number of FI episodes. The device is initially fitted and inflated by a clinician (with the use of a pump) and after proper fitting, the patient can inflate and deflate the device at home as needed. The device should be removed periodically for cleaning.

Claims for services involving the eclipse system should be billed with *Current Procedural Terminology* (CPT®) code 58999 (Unlisted procedure, female genital system) and Healthcare Common Procedure Coding System (HCPCS) code A4335 (incontinence supply, miscellaneous). The claim must also indicate that the eclipse procedure was performed in block 19 on the Centers or Medicare & Medicaid Services (CMS) 1500 claim form (or its electronic equivalent). Payment for HCPCS code A4335 is bundled into the payment for the physician service and is packaged into payment for other services in the hospital outpatient prospective payment system (OPPS). Therefore, there is no separate payment.

Upcoming provider outreach and educational events

Medicare Speaks 2017 Tampa

Date: Wednesday & Thursday, July 26-27
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Medicare_Speaks/0371441.asp

E/M services: Documenting office visits

Date: Wednesday, August 9
Time: 10:00-11:30 a.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0377865.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 May 25, 2017

MLN Connects® for May 25, 2017

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News & Announcements

- Social Security Number Removal Initiative Reminder: Get Your Systems Ready
- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
- Quality Payment Program: Technical Assistance Resource Guide Available
- SNF QRP Quality Measure User's Manual
- Administrative Simplification: Get the Basics
- May is National Osteoporosis Month

Provider Compliance

- Advanced Life Support Ambulance Services: Insufficient Documentation

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — June 15
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28

- CBR on Anesthesia Services for Lower Endoscopic Procedures Webinar — July 12

Medicare Learning Network® Publications & Multimedia

- ABCs of the Initial Preventive Physical Examination Educational Tool — Revised

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MLN Connects® for June 1, 2017

MLN Connects® for June 1, 2017

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News & Announcements

- New Medicare Cards Offer Greater Protection to More Than 57.7 Million Americans
- EHR Incentive Programs: Submit Comments on Proposed Changes by June 13
- New Quality Payment Program Resources Available
- Review 2017 EHR Incentive Program Requirements
- CY 2017 eCQM Resources and Tools

Provider Compliance

- Automatic External Defibrillators: Inadequate Medical Record Documentation

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — June 15
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29

Medicare Learning Network® Publications & Multimedia

- Required Workaround for Hospices Submitting RHC and SIA Payments at the End of Life MLN Matters Article — New
- SBIRT Services Booklet — Revised
- Medicare Basics: Parts A and B Claims Overview Video — Reminder
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet — Reminder

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MLN Connects® for June 8, 2017

MLN Connects® for June 8, 2017

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News & Announcements

- Hospitals and SNFS: Reduce Legionella Risk in Water Systems
- Predictive Qualifying APM Participant Status Announced
- Hospices: Review First Provider Preview Reports by June 30
- IRFs & LTCHs: Review QRP Provider Preview Reports by June 30
- IRF and LTCH Compare Quarterly Refresh
- PEPPER for Short-term Acute Care Hospitals Available
- Quality Payment Program Resources Available
- ONC eMeasurement and Quality Improvement Webinar: Recording Available
- Proposed Revisions to Long-Term Care Facilities' Arbitration Agreements
- World No Tobacco Day

Provider Compliance

- Duplicate Claims Will Not be Paid

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — June 15
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28

- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29

Medicare Learning Network® Publications & Multimedia

- Quality Payment Program Overview Web-Based Training Course — New
- Scheduled End of the Intravenous Immune Globulin Demonstration MLN Matters® Article — New
- Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians Booklet — Reminder
- Medicare Secondary Payer Booklet — Reminder

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MLN Connects® for June 15, 2017

MLN Connects® for June 15, 2017

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News & Announcements

- MIPS Group Reporting: Registration Period Ends June 30
- MIPS Performance Categories: Accepting Future Measures and Activities until June 30
- Chronic Care Management Services: New Connected Care Materials
- National Men's Health Week 2017
- County by County Analysis of Current Projected Insurer Participation in Health Insurance Exchanges

Provider Compliance

- CMS Provider Minute: CT Scans Video

Claims, Pricers & Codes

- 2018 ICD-10-CM Code Files Available

Upcoming Events

- IMPACT Act Special Open Door Forum — June 20
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- Diagnosis and Treatment of Parkinson's Disease Webinar — June 28
- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29

Medicare Learning Network® Publications & Multimedia

- Guidance to Providers that Submit Outpatient Facility Claims and Those That Enter Claims Data via DDE Screens to Reduce Incidence of Claims Not Crossing Over MLN Matters® Article — New

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MLN Connects® for June 22, 2017

MLN Connects® for June 22, 2017

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News & Announcements

- CMS Proposes Quality Payment Program Updates to Increase Flexibility and Reduce Burdens
- Coming in April 2018: New Medicare Card – New Number
- Quality Payment Program: New Resources Available
- Quality Payment Program: View Recordings of Recent Webinars
- Quality Measure Development Plan Annual Report
- SNF QRP Review and Correct Reports Available
- 2015 Physician and Other Supplier Utilization and Payment Data
- 2015 Referring DMEPOS Utilization and Payment Data
- Hospice QRP: Clarifying Coding Guidance for Hospice Item Set
- IRFs & LTCHs: Reminder to Review QRP Provider Preview Reports by June 30
- Hospices: Reminder to Review Provider Preview Reports by June 30
- Minority Research Grant Program: Apply by July 10

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities

Upcoming Events

- CLIA Certificate of Provider-performed Microscopy Webcast — June 28

- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29
- Quality Payment Program Year 2 Proposed Rule Listening Session — July 5
- Creating and Verifying Your National Provider Identifier Call — July 12

Medicare Learning Network® Publications & Multimedia

- Provider Enrollment Revalidation – Cycle 2 MLN Matters® Article — Revised
- Complying with Medical Record Documentation Requirements — Revised

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Quarterly provider update

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

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

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

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: *https://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment

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

Medical policy

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

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866-454-9007
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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: *https://medicare.fcso.com/Feedback/161670.asp*

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

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

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

Electronic data interchange (EDI)
Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

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

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

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

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

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

Websites

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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)

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Electronic funds transfers (EFT) (CMS-588)

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

General inquiries

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888-216-8261 (TTY)

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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

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Jacksonville, FL 32232-5098

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Jacksonville, FL 32231-4021

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Email: *medical.policy@fcso.com*

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Jacksonville, FL 32231-4078

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

Overpayments

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

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

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Jacksonville, FL 32232-5087

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

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Jacksonville, FL 32202-4914

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First Coast University
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Beneficiaries

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