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

In this issue

MLN Connects® Provider eNews – Special Edition

Thursday, July 13, 2017

In this edition:

- Hospital Outpatient, ASC: CMS Proposes 2018 Policy and Rate Changes
- Physician Fee Schedule: CMS Proposes 2018 Payment and Policy Updates

Hospital Outpatient, ASC: CMS Proposes 2018 Policy and Rate Changes

Proposed rule and Request for Information promote improvements to quality, accessibility, and affordability of care

On July 13, CMS issued a proposed rule that updates payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed rule is one of several for 2018 that reflect a broader strategy to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility and innovation in the delivery of care.

The OPPS and ASC payment system are updated annually to include changes to payment policies, payment rates, and quality provisions for those Medicare patients who receive care at hospital outpatient departments or receive care at surgical centers. Among the provisions in this rule, CMS is proposing to change the payment rate for certain Medicare Part B drugs purchased by hospitals through the 340B program. The proposed rule also includes a provision that would alleviate some of the burdens rural hospitals experience in recruiting physicians by placing a two-year moratorium on the direct supervision requirement currently in place at rural hospitals and critical access hospitals. In addition, CMS is releasing within the proposed rule a Request for Information to welcome continued feedback on flexibilities and efficiencies in the Medicare program.

For More Information:

- *Proposed Rule*
- *Fact Sheet*

See the full text of this excerpted *Press Release* (issued July 13).

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Contents

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

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

About the Medicare B Connection

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

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

Who receives the *Connection*

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

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

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

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

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

Publication format

The *Connection* is arranged into distinct sections.

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

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

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

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

Never miss an appeals deadline again

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

Medicare Part B advance beneficiary notices

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

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

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

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

Patient liability notice

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

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

ABN modifiers

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

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

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

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

GA modifier and appeals

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

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

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

October quarterly update to correct coding initiative edits

Provider type affected

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

Provider action needed

Change request (CR) 10183 informs the MACs about the update to the National Correct Coding Initiative (NCCI) procedure to procedure edits (PTP). This notice applies to Chapter 23, Section 20.9 of the *Medicare Claims Processing Manual*. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the NCCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

Version 23.3 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/column 2 correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the outpatient code editor (OCE). It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits. CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file on each website. **The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the column one/column two correct coding edit file.** Refer to the CMS NCCI web page for additional information at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*. The coding policies developed are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology* manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

Additional information

The official instruction, CR 10183, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3807CP.pdf*.

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

Document history

Date of change	Description
July 17, 2017	Initial article released

MLN Matters® Number: MM10183
Related CR Release Date: July 14, 2017
Related CR Transmittal Number: R3807CP
Related Change Request (CR) Number: CR10183
Effective Date: October 1, 2017
Implementation Date: October 2, 2017

How can the PDS help my practice?

The Provider Data Summary (PDS) can help you quickly identify potential billing issues through detailed analysis of personal billing patterns in comparison with those of similar providers. Additional information, including a quick-start guide to help you easily get started right away, is available at *https://medicare.fcso.com/PDS/index.asp.*

Durable Medical Equipment

DMEPOS: Payment for accessories used with group 3 complex rehabilitative power wheelchairs effective July 1

The Centers for Medicare & Medicaid Services is adopting a new interpretation of the statute that impacts how adjustments to the fee schedule based on information from competitive bidding programs apply to wheelchair accessories used with group three complex rehabilitative power wheelchairs. Effective July 1, fee schedule amounts for wheelchair accessories and back and seat cushions used with group three complex rehabilitative power wheelchairs will not be adjusted using information from the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. The fee schedule amounts will be based on the unadjusted fee schedule amounts updated by the annual fee schedule covered item update. Suppliers should continue to use the KU modifier when billing for wheelchair accessories and seat and back cushions furnished in connection with group three complex rehabilitative power wheelchairs with dates of service beginning July 1, 2017.

For more information, view the posting and *FAQ* on the *DME Center* web page.

Preventive Services

Screening for hepatitis B virus infection

***Note**: This article was revised June 30, 2017, to reflect an updated change request (CR) 9859. In the article, the CR release date, transmittal numbers, and the Web address of the CR are revised. All other information is unchanged. This information was previously published in the June 2017 Medicare B Connection, pages 18-22.*

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, ≥ two percent), US-born persons not vaccinated as infants whose parents were born in regions with a very high prevalence of HBV infection (≥ eight percent), HIV positive persons, men who have sex with men, injection drug users, household contacts or sexual partners of persons with HBV infection. In addition, CMS has determined that repeated screening would be appropriate annually for beneficiaries with continued high risk persons. Testing is covered annually only for persons who have continued high risk(men who have sex with men, injection drug users,

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household contacts or sexual partners of persons with HBV infection) who have not received hepatitis B vaccination.

2. A screening test at the first prenatal visit is covered for pregnant women and then rescreening at time of delivery for those with new or continuing risk factors. In addition, CMS has determined that screening during the first prenatal visit would be appropriate for each pregnancy, regardless of previous hepatitis B vaccination or previous negative hepatitis B surface antigen (HBs Ag) test results.

For the purposes of CR 9859:

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

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

Key points of CR 9859

Applicable Healthcare Common Procedure Coding System (HCPCS) code

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

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

Types of bill (TOB) for institutional claims

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

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

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 dervice (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

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- 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
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).

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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

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

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 *http://www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code PR (patient responsibility) - Assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed ABN is on file).
- Group code CO (contractual obligation) - Assigning financial liability to the provider (if a claim 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:

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- 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 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/R3804CP.pdf*. The second transmittal updates the *NCD Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R198NCD.pdf*.

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

Document history

Date	Description
June 30, 2017	This article was revised to reflect an updated CR 9859. In the article, the CR release date, transmittal numbers, and the web address of the CR are revised. All other information is unchanged.
June 9, 2017	The article was revised to reflect an updated CR that changed the implementation date from January 1, 2018, to January 2, 2018.
May 4, 2017	Initial article released.

MLN Matters® Number: MM9859 *Revised*
Related Change Request (CR) #: CR 9859
Related CR Release Date: June 29, 2017
Effective Date: September 28, 2016
Related CR Transmittal #: R3804CP and R198NCD
Implementation Date: January 2, 2018

Modernized national plan and provider enumeration system

Provider type affected

This *MLN Matters*® article is intended for all health care providers – users of the national plan and provider enumeration system (NPPES) to obtain, or update a national provider identifier (NPI) and to maintain their NPI account. This includes all physicians, providers and suppliers–it is not limited or restricted to Medicare.

Provider action needed

The Centers for Medicare & Medicaid Services has modernized the NPPES (NPPES 3.0) that now has unified login for type one and type two providers which increases security, provides new surrogacy functionality, has a more responsive user interface (UI) and a streamlined NPI application process. All NPPES users who obtain and manage NPI account information should be aware of these new and improved features/processes, especially those who support type two providers. NPPES has implemented a more efficient way of accessing type two NPI accounts so providers no longer need separate credentials for type two accounts and are no longer inclined to share these credentials.

Background

The NPI is the standard for a unique identifier for health care providers for use in the health care system. NPPES is the application that health care providers must use to be awarded an NPI number. Within the NPPES, there are two types of providers:

- Type one providers – health care providers who are individuals, including physicians, dentists, and all sole proprietors (an individual is eligible for only one NPI.)
- Type two providers – health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

For more information on the national provider number please visit *https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/downloads/NPIfinalrule.pdf*.

New NPPES impact on type one providers

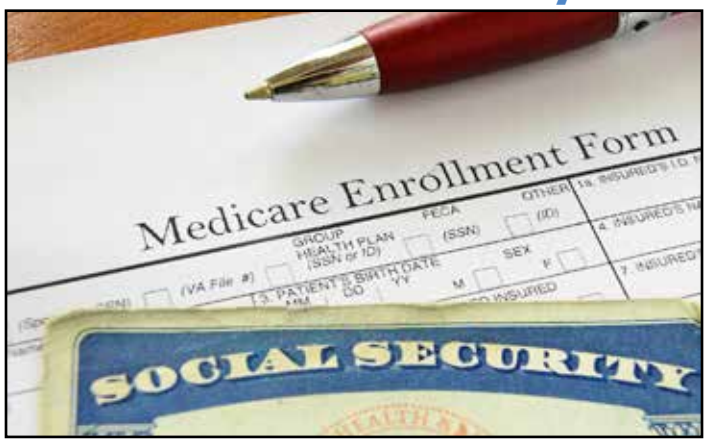
Type one providers who already have an account in the identity & access (I&A) management system may login to NPPES without incident. Type one providers who do not have an I&A account will need to create an account by visiting *https://nppes.cms.hhs.gov/IAWeb/login.do*.

Under the modernized NPPES, surrogates of type 1 providers will have access to their type one provider's NPI records.

For more information on the identity & access management system please visit *https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf*.

New NPPES impact on type two providers

In the past, the sharing of login credentials between type



two providers and surrogates posed great security risks including fraud and provider identity theft. The new unified login and surrogacy helps lessen these risks and increase account security. Type two provider users will need I&A authentication credentials to access the modernized NPPES. Users may obtain these in the I&A system by going to *https://nppes.cms.hhs.gov/IAWeb/login.do*. The authorized officials (AO) and delegated officials (DO) in I&A of type two providers will be able to access all NPIs under the employer identification number (EIN) on the type two provider with an organization EIN. Users can claim NPIs using their legacy type two usernames and passwords after they login with an I&A account. As an additional convenience, large organizations can contact the enumerator to get access to their NPIs. More information on the types of possible user roles is available at *https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf*.

Key features of the modernized NPPES

Some of the key features of the modernized and more responsive UI include:

- If users have an I&A user ID and password, they now can use those credentials to login to NPPES and they can access all NPIs from one unified account.
- Users can save applications that are not fully complete and may continue where they left off when they return to the NPPES.
- NPPES will have smart filters that only display entries containing the data entered by users to filter away unnecessary information.
- Users may add more than one practice location to their NPI application.
- All taxonomy information may be completed on one page due to the smart filter technology of NPPES 3.0.
- Surrogacy allows administrative users the ability to update records in NPPES on behalf of a provider.
- NPPES 3.0 provides a help option to give assistance to the user based on the screen on which they are working.

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- Increased security because NPPES now uses surrogacy functionality for type two NPIs to prevent sharing of type two login credentials.

Electronic file interchange (EFI) features

NPPES 3.0 will continue to allow providers and surrogates to submit multiple NPI applications at one time using comma-separated values (CSV) files. To use the EFI feature, the users will need to apply for EFI access. This can be done by logging into NPPES and clicking the 'manage EFI' button on the bottom of the NPPES homepage. The EFI access application is pre-populated with some of the user's information pre-filled when it is generated. For more information on EFI functionality please visit *https://nppes.cms.hhs.gov/webhelp/nppeshelp/EFI%20HELP%20PAGE.html*.

Data dissemination file (DDS) enhancements

NPPES will generate weekly and monthly org other name, practice location addresses, and endpoint information files. The weekly files will have updates of the information that changes from week to week, while the monthly files will generate regardless of updated information. DDS files with PII will continue to be delivered to stakeholders, while DDS files without PII will continue to be delivered to *https://download.cms.gov/nppes/NPI_Files.html*.

New Optional Fields in NPPES 3.0

The following new fields will allow the user to give more information about the provider and the practice location:

- Primary languages
- Secondary languages
- Race and ethnicity
- Accessibility of the location to users with mobility disabilities
- Provider's office hours of operation
- Provider's direct email address

Frequently asked questions

Feel free to visit the NPPES web help guide to see solutions to frequently asked questions. That guide is available at *https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html*.

Additional information

Additional Information on NPPES is available at the following links:

- *https://www.youtube.com/watch?v=BOJCAj1P2u8&feature=youtu.be*
- *https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html#How-can-I-gain-access-to-my-Type-2-NPI*
- *https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html#Why-cant-I-use-my-Type-2-NPI-User-ID-and-Password-to-log-into-NPPES-to-access-my-NPI*
- *https://nppes.cms.hhs.gov/IAWeb/warning.do?fwdurl=/*

If you have any questions, please contact the NPI enumerator by phone at 1-800-465-3203 (NPI Toll-Free) or 1-800-692-2326 (NPI TTY), by email at *customerservice@npienumerator.com* or by regular mail at:

NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

Document history

Date of change	Description
June 27, 2017	Initial article released

MLN Matters® Number: SE17016
Article Release Date: June 27, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2017, must be paid before the end of business March 31, 2017.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department web page *https://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/rates.htm* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

The new rate of 2.375 percent is in effect through December 31, 2017.

Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

Note: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

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

Note: *The article was revised June 29, 2017, to reflect a revised change request (CR) 9911 issued June 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. Clarifications are also made to the second paragraph of the "Background" section. All other information remains the same. This information was previously published in the May 2017 Medicare A Connection, page 1.*

Provider type affected

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

Provider action needed

CR 9911 modifies the Medicare claims processing systems to help providers more readily identify the qualified Medicare beneficiary (QMB) status of each patient and to support providers' ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare's claims processing systems. This system enhancement will trigger notifications to providers (through the provider remittance advice) and to beneficiaries (through the Medicare summary notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the *Provider Reimbursement Manual (PRM)*.

CR 9911 aims to support Medicare providers' ability to meet these requirements by modifying the Medicare claim processing system to clearly identify the QMB status of all Medicare patients. Currently, neither the Medicare eligibility systems (the HIPAA eligibility transaction system (HETS)), nor the claim processing systems (the FFS shared systems), notify providers about their patient's QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare summary notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

CR 9911 includes modifications to the FFS claims processing systems and the *Medicare Claims Processing Manual* to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare's common working file (CWF) will obtain QMB indicators so the claim processing systems will have access to this information.

- CWF will provide the claim processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims; and outpatient institutional types of bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x); home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x, or 060x; and skilled nursing facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).
- CWF will provide the claims processing systems the QMB indicator if the "through date" falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the remittance advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with three new remittance advice remark codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

- N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

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In addition, the MACs will include a claim adjustment reason code of 209 ("Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with group code OA (other adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional information

The official instruction, CR 9911, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3802CP.pdf*.

For more information regarding billing rules applicable to individuals enrolled in the QMB program, see the *MLN Matters*® article, SE1128, at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf*.

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

Document history

- February 3, 2017 - Initial article released.
- May 1, 2017 - The article was revised to reflect a revised CR 9911 issued April 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. All other information remains the same.
- June 29, 2017 - The article was revised to reflect a revised CR 9911 issued June 28, 2017. In the article, the CR release date, transmittal number, and the web address of CR 9911 are revised. Clarifications were also made to the second paragraph of the *Background* section. All other information remains the same.

MLN Matters® Number: MM9911
Related CR Release Date: June 28, 2017
Related CR Transmittal Number: R3802CP
Related Change Request (CR) Number: CR9911
Effective Date: For claims processed on or after October 2, 2017
Implementation Date: October 2, 2017

Internet Only manual update to Pub. 100-04, Chapter 15

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) 10143 corrects errors in Chapter 15, Section 20.1.4 of the *Medicare Claims Processing Manual*.

Background

CR 10143 corrects errors in Chapter 15, Section 20.1.4 of the *Medicare Claims Processing Manual*. These changes are being made to correct minor typographical errors. No policy, processing, or system changes are anticipated. The change specifies that the year that is associated with the Medicare Modernization Act 2003.

Additional information

The official instruction, CR 10143, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3800CP.pdf*.

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

Document history

Date of change	Description
July 18, 2017	Initial article released

MLN Matters® Number: MM10143
Related CR Release Date: June 23, 2017
Related CR Transmittal Number: R3800CP
Related Change Request (CR) Number: CR10143
Effective Date: July 25, 2017
Implementation Date: July 25, 2017

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 *https://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 *https://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 *https://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.

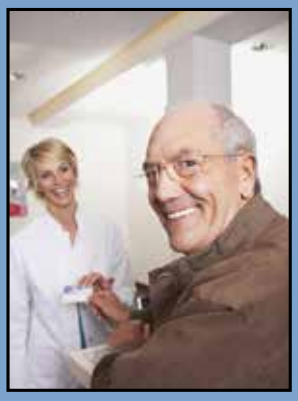
Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

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

Collagenase clostridium histolyticum (Xiaflex®) – retired Part A and Part B LCD

LCD ID number: L33280 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on data analysis review of the collagenase clostridium histolyticum (Xiaflex®) 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 July 06, 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*.

Intravitreal bevacizumab (Avastin®) – retired Part A and Part B LCD

LCD ID number: L33504 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for intravitreal bevacizumab (Avastin®) is being retired based on the development of new LCD (L36962) vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases.

Effective date

The retirement of this 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*.

Macugen (pegaptanib sodium injection) – retired Part B LCD

LCD ID number: L33919 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for macugen (pegaptanib sodium injection) is being retired based on the development of new LCD (L36962) vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases.

Effective date

The retirement of this 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*.

Ranibizumab (Lucentis®) – retired Part A and Part B LCD

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

The local coverage determination (LCD) for ranibizumab (Lucentis®) is being retired based on the development of new LCD (L36962) vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases.

Effective date

The retirement of this 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*.

Revisions to LCD

Bendamustine hydrochloride (Treanda®, Bendeka™) – revision to the Part A and Part B LCD

LCD ID number: L33268 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for bendamustine hydrochloride (Treanda®, Bendeka™) was revised to add the indication "non hodgkins's lymphoma (NHL) - Adult T-cell Leukemia/Lymphoma" to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD under "off-labeled Indications". Also, the ICD-10-CM codes C91.50 and C91.52 were added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Healthcare Common Procedure Coding System (HCPCS) codes J9033 and J9034. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after July 06, 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*.

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

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

Based on change request (CR) 9982 (ICD-10 Coding Revisions to National Coverage Determination [NCDs]), the local coverage determination (LCD) was revised to add ICD-10-CM diagnosis code Z86.000 for Healthcare Common Procedure Coding System (HCPCS) codes G0204, G0206, and G0279.

Effective date

This LCD revision is effective for claims processed **on or after July 3, 2017**, for services rendered **on or after January 1, 2017**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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.

Trastuzumab (Herceptin®) – revision to the Part A and Part B LCD

LCD ID number: L34026 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on a local coverage determination (LCD) reconsideration request, the LCD for trastuzumab (Herceptin®) was revised in the "ICD-10 Codes that Support Medical Necessity" section of the LCD to add ICD-10-CM diagnosis codes C16.1-C16.9. Also, the LCD was revised, in the "Utilization Guidelines" section of the LCD under "Dosage and Administration" to remove the 440 mg per vial supply and replace it with current Food and Drug Administration (FDA) label dosage forms and strengths; 150 mg single-dose vial and 420 mg multiple-dose vial. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after July 14, 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*.

Additional Information

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

An article clarifying the billing of Gel-Syn was previously published *March 2017 Medicare B Connection, page 27*.

This article is to correct the information that was previously published. The dosage for Gel-Syn (Healthcare Common Procedure Coding System [HCPCS] code J7328) is reimbursed per 0.1 mg. Since the weekly dosage for Gel-Syn is 16.8 mg, claims for HCPCS code J7328 should be billed with a quantity billed (Q/B) reflecting "01680", which is equivalent to 168 units. Correct billing of HCPCS code J7328 will prevent a delay in the processing of providers' claims.

Non-coronary and non-cerebrovascular angioplasty with or without stent placement – retired Part A and Part B draft LCD

LCD ID number: DL36971 (Florida, Puerto Rico/U.S. Virgin Islands)

The draft local coverage determination (LCD) for non-coronary and non-cerebrovascular angioplasty with or without stent placement is being retired. The draft LCD was posted for the 45-day comment period the week of September 19, 2016, which was viewable to the public on September 29, 2016. The contractor would like to thank those who submitted comments; however, due to multiple coding descriptor changes and new codes implemented with the annual 2017 Healthcare Common Procedure Coding System (HCPCS) update, the contractor has retired the current draft LCD.

Where do I find...

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

Upcoming provider outreach and educational events

E/M services: Documenting office visits

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

Diabetic shoes – An A/B MAC and DME MAC collaboration webinar

Date: Wednesday, August 16
Time: 12:30-2 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0381841.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 June 29, 2017

MLN Connects® for June 29, 2017
View this edition as a PDF

News & Announcements

- New Medicare Number: Prepare Your Systems for April 2018
- DMEPOS: Payment for Group 3 Complex Rehabilitative Power Wheelchair Accessories Effective July 1
- Quarterly Provider Update

Provider Compliance

- Evaluation and Management: Correct Coding

Upcoming Events

- Quality Payment Program Year 2 Proposed Rule Listening Session – July 5
- DMEPOS Prior Authorization Special Open Door Forum – July 6
- ESRD QIP: Reviewing Your Facility's PY 2018 Performance Data – July 10
- Creating and Verifying Your National Provider Identifier Call – July 12

Medicare Learning Network Publications & Multimedia

- Behavioral Health Integration Services Fact Sheet – New
- Evaluation and Management Services Web-Based Training Course – New
- Dementia Care Call: Audio Recording and Transcript – New
- Medical Privacy of Protected Health Information Fact Sheet – Revised
- Medicare Basics: Commonly Used Acronyms Educational Tool – Revised

SPECIAL

from front page

Physician Fee Schedule: CMS Proposes 2018 Payment and Policy Updates

Proposed rule & Request for Information provide flexibility, support strong patient-doctor relationships

On July 13, CMS issued a proposed rule that would update Medicare payment and policies for doctors and other clinicians who treat Medicare patients in CY 2018. The proposed rule is one of several Medicare payment rules for CY 2018 that reflects a broader strategy to relieve regulatory burdens for providers; support the patient-doctor relationship in healthcare; and promote transparency, flexibility, and innovation in the delivery of care.

The Physician Fee Schedule is updated annually to include changes to payment policies, payment rates, and quality provisions for services furnished to Medicare beneficiaries. This proposed rule would provide greater potential for payment system modernization and seeks public comment on reducing administrative burdens for providing patient care, including visits, care management, and telehealth services. The rule takes steps to better align incentives and provide clinicians with a smoother transition to the new Merit-based Incentive Payment System under the Quality Payment Program. The rule encourages fairer competition between hospitals and physician practices by promoting greater payment alignment, and it would improve the payment for office-based behavioral health services that are often the therapy and counseling services used to treat opioid addiction and other substance use disorders. In addition, the proposed rule makes additional proposals to implement the Center for Medicare and Medicaid Innovation's Medicare Diabetes Prevention Program expanded model starting in 2018.

For More Information:

- *Proposed Rule*
- *Fact Sheet*

See the full text of this excerpted *Press Release* (issued July 13).

MLN Connects® for July 6, 2017

MLN Connects® for July 6, 2017

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News & Announcements

- ESRD: Proposed 2018 Policy and Payment Rate Changes
- ESRD QIP: Prepare for the PY 2018 Preview Period
- QPP: New Resources to Help Clinicians Participate in MIPS
- QPP: New Webpage for Clinicians in Small, Rural, or Underserved Areas
- Open Payments Program Posts 2016 Financial Data

Provider Compliance

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

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2018 Performance Data Call – July 10
- Creating and Verifying Your National Provider Identifier Call – July 12
- Assessing Your Ability to Support Patient Self-Management Webinar – July 19
- ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session – July 26

Medicare Learning Network Publications & Multimedia

- Modernized National Plan and Provider Enumeration System MLN Matters® Article – New
- Infection Control: Hand Hygiene Video – New
- PECOS for Provider and Supplier Organizations Booklet – Reminder
- Medicare Vision Services Fact Sheet – Reminder
- Mass Immunizers and Roster Billing Booklet – Reminder

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MLN Connects® for July 13, 2017

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News & Announcements

- New Medicare Cards with New Numbers: 3 Changes You May Need to Make
- QRDA III Implementation Guide Available
- Quality Payment Program: View Recent Webinar Recordings
- Hospital Discharge Notices
- IPPS Hospitals: FY 2014 S-10 Revisions
- Recognizing National HIV Testing Day

Provider Compliance

- OIG Video: Reporting Fraud to the Office of the Inspector General

Claims, Pricers & Codes

- ICD-10-CM Errata Available

Upcoming Events

- Revised Interpretive Guidance for Nursing Homes and New Survey Process Call – July 25
- ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session – July 26
- IRF Quality Reporting Program Refresher Training Webinar – August 15
- Comparative Billing Report on Drugs of Abuse Testing Webinar – August 23

Medicare Learning Network Publications & Multimedia

- CLIA Webcast: Audio Recording and Transcript – New
- Appeals Call: Audio Recording and Transcript – New
- Acute Care Hospital Inpatient Prospective Payment System Booklet – Reminder
- Skilled Nursing Facility Prospective Payment System Booklet – Reminder
- Ambulatory Surgical Center Fee Schedule Fact Sheet – Reminder
- Ambulance Fee Schedule Fact Sheet – Reminder
- Health Professional Shortage Area Physician Bonus Program Fact Sheet – Reminder
- Suite of Products & Resources for Billers & Coders Educational Tool – Reminder

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MLN Connects® for July 20, 2017

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News & Announcements

- Home Health Agency CoP Final Rule: Effective Date Extended to January 13, 2018
- Hospice Quality Reporting Program: Non-Compliance Letters
- IRF Quality Reporting Program: Non-Compliance Letters
- LTCH Quality Reporting Program: Non-Compliance Letters
- SNF Quality Reporting Program: Non-Compliance Letters
- IRF, LTCH, and SNF Quality Reporting Program Data due August 15
- New PEPPER Available for Home Health Agencies and Partial Hospitalization Programs
- Hospitals: 2018 QRDA Category I Implementation Guide
- Health Care Fraud Takedown: Charges Against Individuals Responsible for $1.3 Billion in Fraud

Provider Compliance

- Billing For Stem Cell Transplants

Claims, Pricers & Codes

- Clinicians: Medicare Part B Crossover Claims Issue Tied to Error Code H31312

Upcoming Events

- Revised Interpretive Guidance for Nursing Homes and New Survey Process Call — July 25
- ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session — July 26
- New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments - Listening Session — August 1

- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health Quality Reporting Program Call — August 17
- LTCH Quality Reporting Program Refresher Training Webinar — August 22

Medicare Learning Network Publications & Multimedia

- Quality Payment Program Listening Session: Audio Recording and Transcript — New
- Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 4] Educational Tool — New
- Medicare Basics: Parts A and B Claims Overview Video — Reminder
- Chronic Care Management Services Fact Sheet — Reminder
- Suite of Products & Resources for Billers & Coders Educational Tool – Reminder

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).

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904-791-8103 (NOT toll-free)

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877-660-1759 (TTY)

The SPOT help desk

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

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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

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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

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

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https://www.medicare.gov

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Fax number (for general inquiries)
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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

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

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Jacksonville, FL 32231-4021

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P.O. Box 44078
Jacksonville, FL 32231-4078

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Jacksonville, FL 32231-4071

Overpayments
Medicare Part B Debt Recovery
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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

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Beneficiaries
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https://www.medicare.gov

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

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904-361-0407 (FAX)

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888-216-8261 (TTY)

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877-847-4992

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877-660-1759 (TTY)

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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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P.O. Box 45098
Jacksonville, FL 32232-5098

Email**:** *askFloridaB@fcso.com*
Online form: *https://medicare.fcso.com/Feedback/161670.asp*

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Jacksonville, FL 32231-4078

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Jacksonville, FL 32231-4071

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Jacksonville, FL 32232-5157

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Jacksonville, FL 32232-5087

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2017 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2017, are available free of charge online at *https://medicare.fcso.com/Data_files/* (English) or *https://medicareespanol.fcso.com/Fichero_de_datos/* (Español). Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. **Note:** Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	$12		
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