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

In this issue

Elimination of the GT modifier for telehealth services

Provider types affected

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

Provider action needed

Change request (CR) 10152 eliminates the requirement to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services. Use of the telehealth place of service (POS) vode 02 certifies that the service meets the telehealth requirements.

Background

CR 10152 revises the previous guidance that instructed practitioners to submit claims for telehealth services using the appropriate CPT® or HCPCS code for the professional service along with the telehealth modifier GT (via interactive audio and video telecommunications systems). The GQ modifier is still required when applicable. As a result of the 2017 physician fee schedule (PFS) final rule, CR 9726 implemented payment policies regarding Medicare's use of a new POS code 02 to describe services furnished via telehealth. The new POS code became effective January 1, 2017. Use of the telehealth POS code certifies that the service meets the telehealth requirements.

Note that for distant site services billed under critical access hospital (CAH) method II on institutional claims, the GT modifier will still be required.

MACs will apply the "one every three days" frequency edit logic for telehealth services when codes 99231, 99232, and 99233 are billed with POS 02 for claims with dates of service January 1, 2018, and after. This frequency editing also applies when these services are span-dated on the claim (that is, the "from" date and the "to" date of service are not equal, and the "units" field is greater than one).

MACs will apply the existing "one every 30 days" frequency edit logic for telehealth services when codes 99307, 99308, 99309, and 99310 are billed with POS 02 for claims with dates of service January 1, 2018, and after. This frequency editing also applies when these services are span-dated on the claim (that is, the "from" date and the "to" date of service are not equal, and the "units" field is greater than one).

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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 *https://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.

Laboratory/Pathology

2018 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

Provider type affected

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

What you need to know

Change request (CR) 10409 provides instructions for the 2018 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests and updates for laboratory costs subject to the reasonable charge payment. Make sure your billing staffs are aware of these changes.

Key points of CR 10409

Fee schedule through December 31, 2017

Outpatient clinical laboratory services are paid based on a fee schedule in accordance with Section 1833(h) of the Social Security Act (the Act). Payment is the lesser of the amount billed, the local fee for a geographic area, or a national limit. In accordance with the statute, the national limits are set at a percent of the median of all local fee schedule amounts for each laboratory test code. Each year, fees are updated for inflation based on the percentage change in the consumer price index. However, legislation by Congress can modify the update to the fees. Co-payments and deductibles do not apply to services paid under the Medicare clinical laboratory fee schedule.

Each year, new laboratory test codes are added to the clinical laboratory fee schedule and corresponding fees are developed in response to a public comment process.

For cervical or vaginal smear tests (pap smears), the fee cannot be less than a national minimum payment amount, initially established at $14.60 and updated each year for inflation, as stated in Section 1833(h)(7) of the Act.

Fee schedule beginning January 1, 2018

Effective January 1, 2018, CLFS rates will be based on weighted median private payer rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, visit PAMA Regulations at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html*. For links to the slide presentations, audio recordings, and written transcripts, see CMS sponsored events, at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/CMS-Sponsored-Events.html*.

Update to fees

In accordance with Section 1833(h)(2)(A)(i) of the Act, available at: *https://www.ssa.gov/OP_Home/ssact/title18/1833.htm*,the annual update to the local clinical laboratory fees for 2018 is 1.10 percent. Beginning January 1, 2018, this update only applies to pap smear tests. For a pap smear test, Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. However, for pap smear tests, payment may also not exceed the actual charge. The 2018 national minimum payment amount is $14.65 ($14.49 times 1.10 percent update for 2018).

The affected codes for the national minimum payment amount are: 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, Q0111, Q0115, and P3000.

The annual update to payments made on a reasonable charge basis for all other laboratory services for 2018 is 1.10 percent (See 42 CFR 405.509(b)(1)).

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Access to data file

Internet access to the 2018 clinical laboratory fee schedule data file will be available after December 1, 2017, at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Other interested parties, such as the Medicaid state agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, may use the internet to retrieve the 2018 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public comments and final payment determinations

On July 31, 2017, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input on the payment relationship between 2017 codes and new 2018 CPT® codes. CMS posted a summary of the meeting and the tentative payment determinations on the website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Laboratory_Public_Meetings.html*. Additional written comments from the public were accepted until October 23, 2017. CMS also posted a summary of the public comments and the rationale for the final payment determinations at the same CMS website.

Pricing information

The 2018 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and

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P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for 2018, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2018 clinical laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Mapping information

New code 81105 is priced at the same rate as code 81376.

New code 81106 is priced at the same rate as code 81376.

New code 81107 is priced at the same rate as code 81376.

New code 81108 is priced at the same rate as code 81376.

New code 81109 is priced at the same rate as code 81376.

New code 81110 is priced at the same rate as code 81376.

New code 81111 is priced at the same rate as code 81376.

New code 81112 is priced at the same rate as code 81376.

New code 81120 is priced at the same rate as code 81275.

New code 81121 is priced at the same rate as code 81311.

New code 81175 is priced at the same rate as code 81317.

New code 81176 is priced at the same rate as code 81218.

New code 81230 is priced at the same rate as code 81227.

New code 81231 is priced at the same rate as code 81227.

New code 81232 is priced at the same rate as code 81227.

New code 81238 is priced at the same rate as code 81321.

New code 81247 is priced at the same rate as code 81227.

New code 81248 is priced at the same rate as code 81215.

New code 81249 is priced at the same rate as code 81321.

New code 81258 is priced at the same rate as code 81215.

New code 81259 is priced at the same rate as code 81321.

New code 81269 is priced at the same rate as code 81294.

New code 81283 is priced at the same rate as code 81241.

New code 81328 is priced at the same rate as code 81227.

New code 81334 is priced at the same rate as code 81272.

New code 81335 is priced at the same rate as code 81227.

New code 81346 is priced at the same rate as code 81227.

New code 81361 is priced at the same rate as code 81227.

New code 81362 is priced at the same rate as code 81215.

New code 81363 is priced at the same rate as code 81294.

New code 81364 is priced at the same rate as code 81235.

New code 81448 is priced at the same rate as code 81435.

New code 81520 is priced at the same rate as code 0008M.

New code 81521 is priced at the same rate as code 81519.

New code 81541 is priced at the same rate as code 81519.

New code 81551 is to be gapfilled.

New code 86008 is priced at the same rate as code 86235.

New code 86794 is priced at the same rate as code 86788.

New code 87634 is priced at the same rate as code 87801.

New code 87662 is priced at the same rate as code 87501.

New code 0001U is to be gapfilled.

New code 0002U is to be gapfilled.

New code 0003U is priced at the same rate as 1.25 times code 0010M.

New code 0005U is priced at the same rate as code 0010M.

New code 0006U is priced at the same rate as code G0483.

New code 0007U is priced at the same rate as code G0480.

New code 0008U is priced at the same rate as code 81445.

New code 0009U is to be gapfilled.

New code 0010U is to be gapfilled.

New code 0011U is priced at the same rate as code G0480.

New code 0012U is to be gapfilled.

New code 0013U is to be gapfilled.

New code 0014U is to be gapfilled.

New code 0016U is priced at the same rate as code 81206.

New code 0017U is priced at the same rate as code 81270.

New code G0499 is priced at the same rate as code 87340 plus 0.05 times code 87341 plus code 86704 plus 0.5 times code 86706.

Reconsidered code 81327 is to be gapfilled.

Existing code 80305 is priced at the same rate as code G0477.

Existing code 80306 is priced at the same rate as code G0478.

Existing code 80307 is priced at the same rate as code G0479.

Existing code 81413 is priced at the same rate as code 81435.

Existing code 81414 is priced at the same rate as code 81436.

Existing code 81422 is priced at the same rate as code 81420.

Existing code 81439 is priced at the same rate as code 81435.

Existing code 81539 is priced at the same rate as code 0010M.

Existing code 84410 is priced at the same rate as code 84402 plus code 84403.

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Existing code 87483 is priced at the same rate as code 87633.

Existing code G0475 is priced at the same rate as code 87389.

Existing code G0476 is priced at the same rate as code 87624.

Existing code G0659 is priced at the same rate as code G0479.

Existing code 80410 is priced at the same rate as 3 times code 82308.

Existing code 80418 is priced at the same rate as four times code 82024 plus four times code 83002 plus four times code 83001 plus four times code 84146 plus four times code 83003 plus four times code 82533 plus four times code 84443.

Existing code 80435 is priced at the same rate as five times code 82947 plus five times code 83003.

Existing code 81316 is priced at the same rate as code 81315.

Existing code 81326 is priced at the same rate as code 81322.

Existing code 81425 is to be gapfilled.

Existing code 81426 is to be gapfilled.

Existing code 81427 is to be gapfilled.

Existing code 81434 is priced at the same rate as code 81445.

Existing code 81470 is to be gapfilled.

Existing code 81471 is to be gapfilled.

Existing code 81506 is priced at the same rate as code 82728 plus code 82947 plus code 83036 plus code 83525 plus code 86141 plus code 83520.

Existing code 82286 is priced at the same rate as code 82310.

Existing code 82387 is priced at the same rate as code 82373.

Existing code 82759 is priced at the same rate as code 82963.

Existing code 82979 is priced at the same rate as code 84220.

Existing code 83662 is priced at the same rate as code 83663.

Existing code 83857 is priced at the same rate as code 84165.

Existing code 83987 is priced at the same rate as code 83986.

Existing code 84085 is priced at the same rate as code 84220.

Existing code 84485 is priced at the same rate as code 82977.

Existing code 84577 is priced at the same rate as code 82710.

Existing code 84580 is priced at the same rate as code 82615.

Existing code 85170 is priced at the same rate as 0.8 times code 85175.

Existing code 85337 is priced at the same rate as code 83520.

Existing code 85400 is priced at the same rate as code 85410.

Existing code 85530 is priced at the same rate as code 85520.

Existing code 86327 is priced at the same rate as code 86320.

Existing code 86821 is priced at the same rate as code 86822.

Existing code 86829 is priced at the same rate as code 86828.

Existing code 87152 is priced at the same rate as code 87158.

Existing code 87267 is priced at the same rate as code 87271.

Existing code 87475 is priced at the same rate as code 87480.

Existing code 87485 is priced at the same rate as code 87480.

Existing code 87495 is priced at the same rate as code 87797.

Existing code 87528 is priced at the same rate as code 87480.

Existing code 87537 is priced at the same rate as code 87534.

Existing code 87557 is priced at the same rate as code 87592.

Existing code 87562 is priced at the same rate as code 87592.

Existing code 88130 is priced at the same rate as code 87209.

Existing code 88245 is priced at the same rate as code 88248.

Existing code 88741 is priced at the same rate as code 88740.

Existing code 89329 is priced at the same rate as code 89331.

Existing code 0002M is priced at the same rate as code 0003M.

Existing code 0004M is to be gapfilled.

Existing code 0006M is to be gapfilled.

Existing code 0007M is to be gapfilled.

Existing code 0009M is to be gapfilled.

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Existing code G0480 is priced at the same rate as four times code 82542 plus 0.75 times code 82542.

Existing code G0481 is priced at the same rate as four times code 82542 plus 2.50 times code 82542.

Existing code G0482 is priced at the same rate as four times code 82542 plus 4.25 times code 82542.

Existing code G0483 is priced at the same rate as four times code 82542 plus 6.25 times code 82542.

Existing code P2028 is priced at the same rate as code 82040.

Existing code P2029 is priced at the same rate as code 82040.

Existing code P2031 is priced at the same rate as code 82040.

Existing code P2033 is priced at the same rate as code 82040.

Existing code P2038 is priced at the same rate as code 82040.

Existing code Q0113 is priced at the same rate as code 87172.

New code 80305QW is priced at the same rate as code 80305.

New code 87633QW is priced at the same rate as code 87633.

New code 87801QW is priced at the same rate as code 87801.

New code G0475QW is priced at the same rate as code G0475.

New code 85025QW is priced at the same rate as code 85025.

The following existing codes are to be deleted:

0008M	83499	83992	84061
86185	86243	86378	86729
86822	87277	87470	87477
87515	88154		

Laboratory costs subject to reasonable charge payment in 2018

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/405_502.pdf* through 42 CFR 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for 2018 is 1.60 percent.

Manual instructions for determining the reasonable charge payment are in the *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8 available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual*, Chapter 8, Section 60.3, available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c08.pdf*, instructs that the reasonable charge basis applies. However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood products

P9010 P9011 P9012 P9016 P9017 P9019 P9020
P9021 P9022 P9023 P9031 P9032 P9033 P9034
P9035 P9036 P9037 P9038 P9039 P9040 P9044
P9050 P9051 P9052 P9053 P9054 P9055 P9056
P9057 P9058 P9059 P9060 P9070 P9071 P9073
P9100

Also, payment for the following codes may be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Section 20.5 through 20.5.4, available at: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS050111.html*.

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

Note: Biologic products not paid on a cost or prospective payment basis but are paid based on Section 1842(o) of

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Changes to the laboratory national coverage determination edit software for January 2018

***Note**: The article was revised November 21, 2017 to reflect a revised change request (CR) 10309 issued November 21. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information remains the same. This information was previously published in the October 2017 Medicare B Connection, page 10.*

Provider type affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (regional home health intermediaries (RHHIs) and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 10309 which informs MACs about the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. CR 10309 applies to Chapter 16, Section 120.2, Publication 100-04. Make sure that your billing staffs are aware of these changes.

See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 10309 announces the changes that will be included in the January 2018 quarterly release of the edit module for clinical diagnostic laboratory services. NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12 - 190.34) were processed uniformly throughout the nation effective April 1, 2003.

In accordance with Chapter 16, Section 120.2, Publication 100-04, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes. CR 10309 communicates requirements to shared system maintainers (SSMs) and contractors, notifying them of changes to the laboratory edit module

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the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047, should be obtained from the Medicare Part B drug pricing files.

Transfusion medicine

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

Reproductive medicine procedures

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

Your MAC will not search their files to either retract payment or retroactively pay claims, however, will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 10409, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3934CP.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
December 15, 2017	Initial article released.

MLN Matters® Number: MM10409
Related CR Release Date: December 15, 2017
Related CR Transmittal Number: R3934CP
Related Change Request (CR) Number: 10409
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Preventive Services

Replacement of mammography codes, waiver of coinsurance and deductible for preventive and other services, and addition of anesthesia and prolonged preventive services

Provider type affected

This *MLN Matters*® article is intended for providers submitting claims to Part A & B Medicare administrative contractors (MACs) for services furnished to Medicare beneficiaries.

Provider action needed

Change request (CR) 10181 provides for the replacement of HCPCS codes G0202, G0204, and G0206 with *Current Procedural Terminology* (CPT®) codes 77067, 77066, and 77065, effective January 1, 2018. CR 10181 also applies the waiver of deductible and coinsurance to 76706, 77067, prolonged preventive services, and anesthesia services furnished in conjunction with and in support of colorectal cancer services. Make sure your billing staffs are aware of these changes.

The language and policy referred to in this article are included in Chapter 18, Sections 20 and 240 (new) of the *Medicare Claims Processing Manual*, which is included as an attachment to CR 10181.

Background

Replacement of mammography HCPCS codes

Effective for claims with dates of service on or after January 1, 2018, the following HCPCS codes are being replaced:

- G0202 - "screening mammography, bilateral (2-view study of each breast), including computer-aided detection computer-aided detection (CAD) when performed"
- G0204 - "diagnostic mammography, including when performed; bilateral" and
- G0206 - "diagnostic mammography, including CAD when performed; unilateral"

These codes are being replaced by the following CPT® codes:

- 77067 - "screening mammography, bilateral (2-view study of each breast), including CAD when performed"
- 77066 - "diagnostic mammography, including (CAD) when performed; bilateral" and
- 77065 - "diagnostic mammography, including CAD when performed; unilateral".

As part of the January 2017 HCPCS code update, code G0389 was replaced by CPT® code 76706. Type of service (TOS) "5" was assigned to 76706, and the coinsurance and deductible were waived.

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NCD

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to update it for changes in laboratory NCD code lists for January 2018. Please access the link below for the NCD spreadsheets included with CR 10309: *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR207300-January2018.zip*.

MACs will adjust claims brought to their attention, but will not search their files to retract payment for claims already paid or retroactively pay claims.

Additional information

The official instruction, CR 10309, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3925CP.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
November 22, 2017	The article is revised to reflect a revised CR 10309 issued November 21. In the article, the CR release date, transmittal number, and the web address of the CR are revised. All other information remains the same.
October 12, 2017	Initial article released.

MLN Matters® Number: MM10309 *Revised*
Related CR Release Date: November 21, 2017
Related CR Transmittal Number: R3925CP
Related Change Request (CR) Number: CR10309
Effective Date: October 1, 2017
Implementation Date: January 2, 2018

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Effective January 1, 2018, the TOS for 76706 will be changed to "4" as part of the 2018 HCPCS update; the coinsurance and deductible will continue to be waived.

Summary of changes: For claims with dates of service January 1, 2017, through December 31, 2017, report HCPCS codes G0202, G0204, and G0206. For claims with dates of service on or after January 1, 2018, report CPT® codes 77067, 77066, and 77065 respectively.

Prolonged preventive services

Section 4104 of the Affordable Care Act defined the term "preventive services" to include "colorectal cancer screening tests," and as a result, it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Social Security Act (the Act) for screening colonoscopies.

In addition, the Affordable Care Act amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes anesthesia services as an inherent part of the screening colonoscopy procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the 2018 physician fee schedule (PFS) final rule, the Centers for Medicare & Medicaid Services (CMS) modified reporting and payment for anesthesia services furnished in conjunction with and in support of colorectal cancer screening services. .

Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services will be payable by Medicare when billed as an add-on to an applicable preventive service that is payable from the Medicare physician fee schedule, and both deductible and coinsurance do not apply.G0513 and G0514 for prolonged preventive services will be added as part of January1, 2018, HCPCS update and the coinsurance and deductible will be waived.

Anesthesia services

Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT® code 00812 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy). CPT® code 00812 will be added as part of January 1, 2018 HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT® code 00812 and waive the deductible and coinsurance.

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT® code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier. CPT® code 00811 will be added as part of the January 1, 2018 HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT® code 00811 and waive only the deductible when submitted with the PT modifier.

Additional information

The official instruction, CR 10181, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3844CP.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
November 24, 2017	Initial article released.

MLN Matters® Number: MM10181
Related CR Release Date: August 18, 2017
Related CR Transmittal Number: R3844CP
Related Change Request (CR) Number: 10181
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Radiology

Payment reduction for X-rays taken using computed radiography

Provider type affected

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

Provider action needed

This article is based on change request (CR) 10188 which announces that beginning January 1, 2018, and including calendar years 2018-2022, a payment reduction of seven percent applies to the technical component (and the technical component of the global fee) for computed radiography services that would otherwise be made under the physician fee schedule (PFS) (without application of subparagraph (B)(i) and before application of any other adjustment), or under the hospital outpatient prospective payment system (OPPS).

Similarly, if such X-ray services are furnished during 2023 or a subsequent year, a payment reduction of 10 percent applies to the technical component (and the technical component of the global fee) for computed radiography services.

See the *Background* and *Additional information* sections of this article for further details, and make sure that your billing staffs are aware of these changes.

Background

New paragraph 1848 (b)(9) of the Social Security Act (SSA) provides that payments for imaging services that are X-rays taken using computed radiography (including the technical component portion of a global service) furnished during 2018, 2019, 2020, 2021, or 2022, that would otherwise be made under the Medicare physician fee schedule (MPFS) (without application of subparagraph (B)(i) and before application of any other adjustment), be reduced by seven percent, and similarly, if such X-ray services are furnished during 2023 or a subsequent year, by 10 percent. Computed radiography technology is defined for purposes of this paragraph as cassette-based imaging which utilizes an imaging plate to create the image involved.

The statutory provision requires that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable CR service was furnished, and that such information may be included on a claim and may be a modifier.

The statutory provision also provides that such information will be verified, as appropriate, as part of the periodic accreditation of suppliers under SSA Section 1834(e) (*https://www.ssa.gov/OP_Home/ssact/title18/1834.htm*) and hospitals under SSA Section 1865(a) (*https://www.ssa.gov/OP_Home/ssact/title18/1865.htm*). Any reduced expenditures resulting from this provision are not budget neutral.

To implement this provision, the Centers for Medicare & Medicaid Services (CMS) created modifier FY (Computed radiography services furnished). Beginning in 2018, claims for computed radiography services that are furnished for X-rays must include modifier FY that will result in the applicable payment reduction.

MACs will use the following messages when adjusting computed radiography claim lines that have been reported with the FY modifier:

- Remittance advice remark code (RARC) N794 - Payment adjusted based on type of technology used
- Claim adjustment reason code (CARC) CARC 237 - Legislated/Regulatory Penalty
- Group code - CO

For claims billed with the FY modifier and another X-ray reduction modifier on the same line, contractors shall apply both reductions if applicable. The FY modifier reduction will be applied after the other reduction (for example, claims billed with both FX and FY modifier will have the FX modifier reduction applied first).

Additional information

The official instruction, CR 10188, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3820CP.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
November 28, 2017	Initial article released.

MLN Matters® Number: MM10188
Related CR Release Date: July 28, 2017
Related CR Transmittal Number: R3820CP
Related Change Request (CR) Number: 10188
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Therapy Services

2018 annual update to the therapy code list

Provider type affected

This *MLN Matters*® article is intended for physicians, therapists, and other providers, including comprehensive outpatient rehabilitation facilities (CORFs), submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 10303 updates the list of codes that sometimes or always describe therapy services and their associated policies. The additions, changes, and deletions to the therapy code list reflect those made in the 2018 Healthcare Common Procedure Coding System and *Current Procedural Terminology*, Fourth Edition (HCPCS/CPT®-4). The therapy code listing is available at *https://www.cms.gov/Medicare/Billing/TherapyServices/index.html*. Make sure your billing staffs area aware of these updates.

Background

The Social Security Act (Section 1834(k)(5)), available at *https://www.ssa.gov/OP_Home/ssact/title18/1834.htm*, requires that all claims for outpatient rehabilitation therapy services and all CORF services be reported using a uniform coding system. The 2018 Healthcare Common Procedure Coding System and *Current Procedural Terminology*, fourth edition (HCPCS/CPT-4) is the coding system used for the reporting of these services.

The policies implemented in CR 10303 were discussed in 2018 Medicare physician fee schedule (MPFS) rulemaking. CR 10303 updates the therapy code list and associated policies for 2018, as follows:

- The *Current Procedural Terminology* (CPT®) editorial panel revised the set of codes physical and occupational therapists use to report orthotic and prosthetic management and training services by differentiating between initial and subsequent encounters through the: (a) addition of the term "initial encounter" to the code descriptors for CPT® codes 97760 and 97761, (b) creation of CPT® code 97763 to describe all subsequent encounters for orthotics and/or prosthetics management and training services, and (c) deletion of CPT® code 97762. The new long descriptors for CPT® codes 97760 and 97761 – now intended only to be reported for the initial encounter with the patient – are:
  - CPT® code 97760 (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes)
  - CPT® code 97761 (Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes)

- The Centers for Medicare & Medicaid Services (CMS) will add CPT® code 97763 to the therapy code list and CPT® code 97762 will be deleted.
- The panel also created, for 2018, CPT® code 97127 to replace/delete CPT® code 97532. CMS will recognize HCPCS code G0515, instead of CPT® code 97127, and add HCPCS code G0515 to the therapy code list. CPT® code 97127 will be assigned a Medicare physician fee schedule (MPFS) payment status indicator of "I" to indicate that it is "invalid" for Medicare purposes and that another code is used for reporting and payment for these services.
- Just as its predecessor code was, CPT® code 97763 is designated as "always therapy" and must always be reported with the appropriate therapy modifier, GN, GO or GP, to indicate whether it's under a speech-language pathology (SLP), occupational therapy (OT) or physical therapy (PT) plan of care, respectively.
- HCPCS code G0515 is designated as a "sometimes therapy" code, which means that an appropriate therapy modifier − GN, GO or GP, to reflect it's under an SLP, OT, or PT plan of care – is always required when this service is furnished by therapists; and, when it's furnished by or incident to physicians and certain nonphysician practitioners (NPPs), that is, nurse practitioners, physician assistants, and clinical nurse specialists when the services are integral to an SLP, OT, or PT plan of care. Accordingly, HCPCS code G0515 is sometimes appropriately reported by physicians, NPPs, and psychologists without a therapy modifier when it is appropriately furnished outside an SLP, OT, or PT plan of care. When furnished by psychologists, the services of HCPCS code G0515 are never considered therapy services and may not be reported with a GN, GO, or GP therapy modifier.
- The therapy code list is updated with one new "always therapy" code and one new "sometimes therapy" code, using their HCPCS/CPT® long descriptors, as follows:

See **CODE**, next page

Updated editing of always therapy services – MCS

***Note**: This article was revised December 21, 2017, to reflect an updated change request (CR) 10176. The CR was revised to delete HCPCS code 97532 from the list of therapy codes in the attachment to the CR. That code is also removed from the list of those codes in this article. Also, in the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged. This information was previously published in the September 2017 Medicare B Connection, pages 17-19.*

Provider type affected

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

Provider action needed

CR 10176 implements revised editing of Part B "always therapy" services to require the appropriate therapy modifier in order for the service to be accurately applied to the therapy cap. CR 10176 contains no new policy. Instead, the guidelines presented in the CR improve the enforcement of longstanding, existing instructions. Make sure your billing staffs are aware of these revisions.

Background

Services furnished under the outpatient therapy (OPT) services benefit – including speech-language pathology (SLP), occupational therapy (OT), and physical therapy (PT) – are subject to the financial limitations, known as therapy caps, originally required under Section 4541 of the Balanced Budget Act (1997).

There are two such caps. One cap is for PT and SLP services combined and another cap is for OT services. In order to accrue incurred expenses to the correct therapy cap; the use of one of the three therapy modifiers (GN, GO, or GP) is required on a certain set of Healthcare Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under an SLP, OT, or PT plan of care, respectively.

Medicare recognizes the services furnished under the OPT services benefit as either "always" or "sometimes" therapy and publishes this list as an *Annual Update on the Therapy Services Billing* page at *https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html*.

On professional claims, each code designated as "always therapy":

- Must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such,
- Must always be accompanied by one of the GN, GO, or GP therapy modifiers.

In addition, several "always therapy" codes have been identified as discipline-specific – requiring the GN modifier for six codes, the GO modifier for four codes, and the GP modifier for four codes, as illustrated in Tables 1-3.

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CODE

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- CPT® code 97763 – This "always therapy" code replaces/deletes CPT® code 97762.
- CPT® code 97763: Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
- HCPCS code G0515 – This "sometimes therapy" code replaces/deletes CPT® code 97532.
- CPT® code 97763 – This "always therapy" code replaces/deletes CPT® code 97762.
- CPT® code 97763: Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
- HCPCS code G0515 – This "sometimes therapy" code replaces/deletes CPT® code 97532.

Additional information

The official instruction, CR 10303, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3924CP.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
November 21, 2017	Initial article released.

MLN Matters® Number: MM10303
Related Change Request (CR) Number: 10303
Related CR Release Date: November 16, 2017
Effective Date: January 1, 2018
Implementation Date: January 2, 2018
Related CR Transmittal Number: R3924CP

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Table 1: Codes requiring the "GN" therapy modifier

Code	CPT® short descriptor	Therapy modifier required
92521	Evaluation of speech fluency	GN
92522	Evaluate speech production	GN
92523	Speech sound lang comprehend	GN
92524	Behavral quality analys voice	GN
92597	Oral speech device eval	GN
92607	Ex for speech device rx 1hr	GN

Table 2: Codes requiring the "GO" therapy modifier

Code	CPT® short descriptor	Therapy modifier required
97165	Ot eval low complex 30 min	GO
97166	Ot eval mod complex 45 min	GO
97167	Ot eval high complex 60 min	GO
97168	Ot re-eval est plan care	GO

Table 3: Codes requiring the "GP" therapy modifier

Code	CPT® short descriptor	Therapy modifier required
97161	Pt eval low complex 20 min	GP
97162	Pt eval mod complex 30 min	GP
97163	Pt eval high complex 45 min	GP
97164	Pt re-eval est plan care	GP

The following "always therapy" HCPCS codes require a GN, GO, or GP modifier, as appropriate. Descriptors for these codes are included as an attachment to CR 10176.

92507 92508 92526 92608 92609 96125 97012 97016 97018 97022 97024 97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113 97116 97124 97139 97140 97150 97530 97533 97535 97537 97542 97750 97755 97760 97761 97762 97799 G0281 G0283 G0329

In addition to therapists in private practice (TPPs) – including physical therapists, occupational therapists, and speech-language pathologists – professional claims for OPT services may be furnished by physicians and certain non-physician practitioners (NPPs) – specifically, physician assistants, nurse practitioners, and certified nurse specialists.

All OPT services furnished by TPPs are always considered therapy services, regardless of whether they are designated as "always therapy" or "sometimes therapy." As such, the appropriate therapy modifier must be included on the claim. However, it may be clinically appropriate for physicians and NPPs to furnish OPT services that have been designated "sometimes therapy" codes outside a therapy plan of care - in these cases, therapy modifiers are not required and claims may be processed without them.

During analyses of Medicare claims data for OPT services, the Centers for Medicare & Medicaid Services (CMS) found that these "always therapy" codes and modifiers are not always used in a correct and consistent manner. CMS found OPT professional claims for "always therapy" codes without the required modifiers. Also, CMS found claims that reported more than one therapy modifier for the same therapy service; for example, both a GP and GO modifier, when only one modifier was allowed.

These claims represent non-compliant billing by TPPs, physicians, and NPPs, and hamper CMS' ability to properly track the therapy caps and analyze claims data for purposes of Medicare program improvements. The requirements in CR 10176 will create new edits for Medicare professional claims processing systems to return claims when "always therapy" codes and the associated therapy modifiers are improperly reported.

Providers should expect the following:

- MACs will return/reject claims which contain an "always therapy" procedure code, but do not also contain the appropriate discipline-specific therapy modifier of GN, GO, or GP.
- MACs will also return/reject claims if any service line on the claim contains more than one occurrence of a GN, GO, or GP therapy modifier.
- MACs who are returning/rejecting such claims will use group code CO and claim adjustment reason code (CARC) 4 on the related remittance advice.

Additional information

The official instruction, CR 10176, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3936CP.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
December 21, 2017	The article was revised to reflect an updated CR. The CR was revised to remove HCPCS code 97532 from the list of always therapy codes in the attachment to the CR. That code is also removed from the list of those codes in this article. Also, in the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.

See **EDITING**, next page

Inpatient rehabilitation facility medical review changes

Provider type affected

This *MLN Matters*® article is intended for inpatient rehabilitation facilities (IRFs), physicians, and other practitioners with patients in IRFs who are receiving Part A inpatient services.

Provider action needed

Special edition article SE17036 reiterates policy related to claims submitted with regard to services provided to Medicare beneficiaries IRFs. Please make sure your billing and coding staffs review these policies associated with the Medicare IRF benefit.

Background

The Medicare IRF benefit provides intensive rehabilitation therapy in a resource intensive inpatient hospital environment, including inpatient rehabilitation hospitals and inpatient rehabilitation units. The IRF benefit is for a beneficiary who, due to the complexity of their nursing, medical management, and rehabilitation needs, requires and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to rehabilitation care.

In order for IRF services to be covered under the Medicare IRF benefit, submitted documentation must sufficiently demonstrate that a beneficiary's admission to an IRF was reasonable and necessary, according to Medicare guidelines. Key elements of IRF coverage criteria include a reasonable expectation that at the time of the beneficiary's admission to the IRF the beneficiary:

- Requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics) one of which must be physical or occupational therapy
- Generally requires an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least three hours of therapy per day at least five days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a seven consecutive day period, beginning with the date of admission to the IRF
- Is sufficiently stable and can reasonably be expected to be able to actively participate in, and benefit significantly from, an intensive rehabilitation therapy program. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed period of time
- Requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least three days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. (See 42 CFR 412.622, which is available at *https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec412-622.pdf*.)
- Requires an intensive and coordinated interdisciplinary approach to providing rehabilitation

Required documentation elements for an IRF claim include, but are not limited to:

- A comprehensive preadmission screening that is:
  - Conducted by a licensed or certified clinician(s) designated by a rehabilitation physician
  - Completed within the 48 hours immediately preceding the IRF admission
  - Provides a detailed and comprehensive review of each patient's condition and medical history

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Date of change	Description
September 15, 2017	The article was revised to reflect an updated CR. In the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.
July 31, 2017	Initial article released.

MLN Matters® Number: MM10176 *Revised*
Related CR Release Date: December 21, 2017
Related CR Transmittal Number: R3936CP
Related Change Request (CR) Number: 10176
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

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A post-admission physician evaluation that:

- Is conducted by a rehabilitation physician
- Is completed within 24 hours of the patient's admission to the IRF
- Provides documentation of the patient's status on admission to the IRF, including a comparison with the information noted in the preadmission screening documentation
- Support the medical necessity of the IRF admission

An individualized plan of care that:

- Is developed by a rehabilitation physician with input from the interdisciplinary team
- Is based on the findings of the post-admission physician evaluation
- Is completed within the first 4 days of the IRF admission
- Supports the determination that the IRF admission is reasonable and necessary

- Admission orders
- An inpatient rehabilitation facility patient assessment instrument (IRF-PAI)

Particular attention should be paid to documenting the patient's need for intensive rehabilitation therapy services requiring care in an IRF. Documentation in the patient's medical record must be accurate and avoid vague or subjective descriptions of the patient's care needs that would not be sufficient to indicate the need for intensive rehabilitation services.

Recently, the Centers for Medicare & Medicaid Services (CMS) advised its medical review contractors that when the current industry standard of providing in general at least three hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics) per day at least five days per week or at least 15 hours of intensive rehabilitation therapy within a seven-consecutive day period is not met, the claim should undergo further review. This further review will require the use of clinical review judgment to determine medical necessity of the intensive rehabilitation therapy program based on the individual facts and circumstances of the case, and not on the basis of any threshold of therapy time.

Also, CMS advised its medical review contractors that the standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group and concurrent therapy can be used on a limited basis within the current industry standard of generally three hours of therapy per day at least five days per week or at least 15 hours of intensive rehabilitation therapy within a seven-consecutive day period. In those instances in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record at the IRF.

For more information on billing and payment criteria related to IRFs, please refer to the following documentation:

- Chapter 3, Section 140.1.1 of the *Medicare Claims Processing Manual* (Pub. 100-04), titled, *Criteria That Must Be Met By Inpatient Rehabilitation Facilities*, which can be downloaded at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf*
- Chapter 1, Section 110 of the *Medicare Benefit Policy Manual* (IRF Services), available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf*
- 42 CFR 412.622, which is available at *https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec412-622.pdf*

Additional information

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
December 11, 2017	Initial article released.

MLN Matters® Number: SE17036
Article Release Date: December 11, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Wound Care

Coverage of topical oxygen for the treatment of chronic wounds

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.

What you need to know

Change request (CR) 10220 informs MACs that, effective April 3, 2017, coverage of topical oxygen for the treatment of chronic wounds will be determined by the MACs. Make sure your billing staffs are aware of this change.

Background

The Centers for Medicare & Medicaid Services (CMS) received a reconsideration request to remove the coverage exclusion of continuous diffusion of oxygen therapy (CDO) from the *Medicare National Coverage Determinations (NCD) Manual* (Pub. 100-03, Ch.1, Part 1, 20.29, *Hyperbaric Oxygen (HBO) Therapy*, Section C). This section of the NCD (*Topical Application of Oxygen*) considers treatment known as CDO as the application of topical oxygen and nationally non-covers this treatment. CMS asserts that the topical application of oxygen does not meet the definition of HBO therapy as stated in NCD 20.29.

Effective April 3, 2017, CMS decided that no NCD is appropriate at this time concerning the use of topical oxygen for the treatment of chronic wounds. As a result, CMS will amend NCD 20.29 by removing Section C, *Topical Application of Oxygen*. Medicare coverage of topical oxygen for the treatment of chronic wounds will be determined by your MAC.

Note: Although a MAC has discretion to cover topical oxygen for the treatment of chronic wounds, there shall be no coverage for any separate or additional payment for any physician's professional services related to this procedure.

Additional information

The official instruction, CR 10220, consists of two transmittals. The first updates the *Medicare Claims Processing Manual* and is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3921CP.pdf*. The second updates the *National Coverage Determinations Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R203NCD.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
November 22, 2017	Initial article released.

MLN Matters® Number: MM10220
Related CR Release Date: November 17, 2017
Related CR Transmittal Number: R3921CP and R203NCD
Related Change Request (CR) Number: 10220
Effective Date: April 3, 2017
Implementation Date: December 18, 2017

TELEHEALTH

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Additional information

The official instruction issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and- Guidance/Guidance/Transmittals/2017Downloads/R3929CP.pdf*.

To review the *MLN Matters*® article 9726 related to this CR you may go to: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network- MLN/MLNMattersArticles/downloads/MM9726.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
December 4, 2017	Initial article released.

MLN Matters® Number: MM10152
Related CR Release Date: November 29, 2017
Related CR Transmittal Number: R3929CP
Related Change Request (CR) Number: 10152
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

General Coverage

ICD-10 and other coding revisions to national coverage determinations

Provider type affected

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

Provider action needed

Change request (CR) 10318 constitutes a maintenance update of the International Code 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 follow the link below for the NCD spreadsheets included with this CR:

https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10318.zip

Background

Previous NCD coding changes appear in ICD-10 quarterly updates available 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.

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

Note: The translations from 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.

CR 10318 makes coding and clarifying adjustments to the following NCDs:

1. NCD20.9 Artificial Hearts
2. NCD20.9.1 Ventricular Assist Devices (VADs)
3. NCD20.16 Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)
4. NCD20.29 Hyperbaric Oxygen (HBO) Therapy
5. NCD20.30 Microvolt T-Wave Alternans (MTWA)
6. NCD20.33 Transcatheter Mitral Valve Repair (TMVR)
7. NCD40.1 Diabetes Self-Management Training (DSMT)
8. NCD80.2, 80.2.1, 80.3, 80.3.1 Photodynamic Therapy, OPT, Photosensitive Drugs, Verteporfin
9. NCD110.18 Aprepitant
10. NCD110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer
11. NCD110.23 Stem Cell Transplants
12. NCD160.27 Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)
13. NCD190.3 Cytogenetic Studies
14. NCD190.11 Home Prothrombin Time/International Normalized Ratio (PT/INR) for Anticoagulation Management
15. NCD220.4 Mammograms
16. NCD220.6.17 Positron Emission Tomography (FDG) for Solid Tumors
17. NCD260.1 Adult Liver Transplantation
18. NCD220.13 Percutaneous Image-Guided Breast Biopsy
19. NCD270.1 Electrical Stimulation/Electromagnetic Therapy (ES/ET) for Wounds

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20. NCD270.3 Blood-Derived Products for Chronic Non-Healing Wounds
21. NCD80.11 Vitrectomy

When denying claims associated with the above NCDs, except where otherwise indicated, MACs will use.

- Remittance advice remark codes (RARC) N386 with claim adjustment reason code (CARC) 50, 96, and/or 119.
- Group code PR (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed advance beneficiary notice (ABN) is on file).
- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
- For modifier GZ, use CARC 50

Additional information

The official instruction, CR 10318, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1975OTN.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
November 16, 2017	Initial article released.

MLN Matters® Number: MM10318
Related Change Request (CR) Number: 10318
Related CR Release Date: November 9, 2017
Effective Date: April 1, 2018 - Unless otherwise noted in CR 10318
Related CR Transmittal Number: R1975OTN
Implementation Date: December 29, 2017, for local MAC edits; April 2, 2018, for shared system edits (except FISS for NCDs (see above) 1, 8, 12, 19, 21); July 2, 2018, FISS only for NCDs 1, 8, 12, 19, 21

New Medicare cards

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.

The new Medicare cards will be mailed between April 2018 and April 2019. Resources are available to prepare you for this change at *https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp.*

Update to Medicare deductible, coinsurance, and premium rates for 2018

Provider type affected

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

Provider action needed

Change request (CR) 10405 provides instruction for MACs to update the claims processing system with the new 2018 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for health insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30 - 39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for two years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

2018 Part A hospital insurance (HI)

- Deductible: $1,340.00
- Coinsurance
  - $335.00 a day for 61st - 90th day
  - $670.00 a day for 91st - 150th day (lifetime reserve days)
  - $167.50 a day for 21st - 100th day (skilled nursing facility coinsurance)
- Base premium (BP): $422.00 a month BP with 10 percent surcharge: $464.20 a month
- BP with 45 percent reduction: $232.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45 percent reduction and 10 percent surcharge: $255.20 a month

2018 Part B - Supplementary Medical Insurance (SMI)

- Standard premium: $134.00 a month
- Deductible: $183.00 a year
- Pro rata data amount:
  - $126.88 1st month
  - $56.12 2nd month
- Coinsurance: 20 percent

Additional information

The official instruction, CR 10405, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R111GI.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
December 8, 2017	Initial document released.

MLN Matters® Number: MM10405
Related CR Release Date: December 8, 2017
Related CR Transmittal Number: R111GI
Related Change Request (CR) Number: CR10405
Effective Date: January 1, 2018
Implementation Date: January 2, 2018

Prohibition on billing dually eligible individuals enrolled in the QMB program

***Note**: This article was revised to indicate that December 8, 2017, CMS will suspend modifications to the provider remittance advice and the Medicare summary notice for qualified Medicare beneficiary (QMB) claims made October 2, 2017. The article was also revised to show the HETS QMB release was implemented in November 2017. Finally, the article was changed to clarify that QMBs cannot elect to pay Medicare cost-sharing but may need to pay a small Medicaid copay in certain circumstances. All other information remains the same. This information was previously published in the November 2017 Medicare B Connection, pages 17-19.*

Provider types affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in original Medicare or a Medicare advantage (MA) plan.

Provider action needed

This special edition *MLN Matters*® article from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers and suppliers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing.** Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Look for new information and messages in CMS' HIPAA eligibility transaction system (HETS) (effective November 2017) to identify beneficiaries' QMB status and exemption from cost-sharing prior to billing. If you are an MA provider, contact the MA plan for more information about verifying the QMB status of plan members. Implement key measures to ensure compliance with QMB billing requirements. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the states in which you practice. Refer to the *Background* and *Additional information* sections for further details and important steps to promote compliance.

Note that October 2, 2017, the provider remittance (RA) and the Medicare summary notice (MSN) for QMB claims began identifying the QMB status of beneficiaries' and reflecting their zero cost-sharing liability. However, the RA changes caused unforeseen issues affecting the processing of QMB cost-sharing claims by states and other payers secondary to Medicare. To address these unanticipated consequences, beginning December 8, 2017, CMS will temporarily suspend the system changes, reverting back to the previous display of beneficiary responsibility and absence of QMB information on the Medicare RA and MSN. CMS is working aggressively to remediate these issues, with the goal of reintroducing QMB information in the RA and MSN in 2018.

Background

All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must refrain from charging individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill state Medicaid programs for these costs, but states can limit Medicare cost-sharing payments under certain circumstances.

Billing of QMBs is prohibited by federal law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a state Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program. See the chart at the end of this article for more information about the QMB benefit.

Providers and suppliers may bill state Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by federal law, states can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

Note that certain types of providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt. For more information about bad debt, refer to Chapter 3 of the *Provider Reimbursement Manual* (Pub.15-1).

Refer to the *Important reminders concerning QMB billing requirements* section for key policy clarifications.

Inappropriate billing of QMB individuals persists

Despite federal law, improper billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to *Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015*.

See **QMB**, next page

QMB

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Ways to promote compliance with QMB billing rules

Take the following steps to ensure compliance with QMB billing prohibitions:

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.
   - Beginning in November 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS' HETS to verify a patient's QMB status and exemption from cost-sharing charges. For more information on HETS, visit *https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html*.
   - In 2018, CMS will reintroduce QMB information in the Medicare RA that original Medicare providers and suppliers can use to identify the QMB status of beneficiaries.
   - MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.
2. Providers and suppliers may also verify beneficiaries' QMB status through state online Medicaid eligibility systems in the state in which the person is a resident or by asking beneficiaries for other proof, such as their Medicaid identification card or documentation of their QMB status. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.
3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the states in which the beneficiaries you serve reside. Different processes may apply to original Medicare and MA services provided to individuals enrolled in the QMB program. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.
   - If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.

States require all providers, including Medicare providers, to enroll in their Medicaid system for provider claims review, processing, and issuance of the Medicaid RA. Providers should contact the state Medicaid agency for additional information regarding Medicaid provider enrollment.

Important reminders concerning QMB billing requirements

Be aware of the following policy clarifications on QMB billing requirements:

1. All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must abide by the billing prohibitions.
2. Individuals enrolled in the QMB program retain their protection from billing when they cross state lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is provided by a different state than the state in which care is rendered.
3. Note that individuals enrolled in QMB **cannot** elect to pay the Medicare deductibles, coinsurance, and copays. However, a QMB who also receives full Medicaid may have a small Medicaid copay.

QMB eligibility and benefits (see page 22)

Additional information

For more information about dual eligibles under Medicare and Medicaid, please visit *https://www.medicaid.gov/affordable-care-act/dual-eligibles/index.html* and *https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html* and refer to *Dual Eligible Beneficiaries Under Medicare and Medicaid*. For general Medicaid information, please visit *http://www.medicaid.gov/index.html*.

Document history

Date of change	Description
December 4, 2017	The article was revised to indicate that December 8, 2017, CMS will suspend modifications to the provider remittance advice and the Medicare summary notice for QMB claims made October 2, 2017. The article was also revised to show the HETS QMB release was implemented in November 2017. Finally, the article was changed to clarify that QMBs cannot elect to pay Medicare cost-sharing but may need to pay a small Medicaid copay in certain circumstances. All other information remains the same.
November 3, 2017	Article revised to show the HETS QMB release will be in November 2017. All other information remains the same.
October 18, 2017	The article was revised to indicate that the provider remittance advice and the Medicare summary notice for beneficiaries identifies the QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017, and to recommend how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements. All other information remains the same.

See **QMB**, next page

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Date of change	Description
August 23, 2017	The article was revised to highlight upcoming system changes that identify the QMB status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.
May 12, 2017	This article was revised May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the QMB program. All other information is the same.
January 12, 2017	This article was revised to add a reference to *MLN Matters*® article *MM9817*, which instructs Medicare administrative contractors to issue a compliance letter instructing named providers to refund any erroneous charges and recall any existing billing to QMBs for Medicare cost sharing.
February 4, 2016	The article was revised February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under *Important Clarifications Concerning QMB Balance Billing Law*.
February 1, 2016	The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table.
March 28, 2014	The article was revised to change the name of the coordination of benefits contractor (COBC) to BCRC.

MLN Matters® Number: SE1128 *Revised*
Related Change Request (CR) #: N/A
Release Date of Revised Article: December 4, 2017
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

QMB eligibility and benefits

Program	Income criteria*	Resources criteria*	Medicare Part A and Part B enrollment	Other criteria	Benefits
QMB only	≤100% of federal poverty line (FPL)	≤3 times SSI resource limit, adjusted annually in accordance with increases in consumer price index	Part A***	Not applicable	▪ Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid state plan (even if payment is not available under the state plan for these charges, QMBs are not liable for them)
QMB plus	≤100% of FPL	Determined by state	Part A***	Meets financial and other criteria for full Medicaid benefits	▪ Full Medicaid coverage ▪ Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid state plan (even if payment is not available under the state plan for these charges, QMBs are not liable for them)

* States can effectively raise these Federal income and resources criteria under Section *1902(r)(2)* of the Act.

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a "conditional basis"). For more information on this process, refer to Section HI 00801.140 of the *Social Security Administration Program Operations Manual System*.

Administrative relief and guidance on appeals issues related to natural disasters

The following provides responses to questions received by the Centers for Medicare & Medicaid Services (CMS) and to clarify guidance regarding appeals issues for past and future natural disasters.

Situation 1: A provider/supplier/beneficiary in the affected area needs an extension to file a request for an appeal.

Action: The Medicare administrative contractor (MAC)/ durable medical equipment Medicare administrative contractor (DME MAC) shall grant an extension to request an appeal under the good cause exception. Please see *42 CFR 405.942*. If the request is related to an overpayment, the MAC/DME MAC shall accept the request and stop recoupment immediately.

Questions:

Q. Must the provider/supplier/beneficiary indicate they have been impacted by a natural disaster in order to grant additional time or should the MAC/DME MAC apply the consideration to the all providers/suppliers in the affected areas?

A. Yes. Once notified, the MAC/DME MAC shall verify if a provider/supplier/beneficiary resides within an affected area. The consideration shall not be applied to all providers/suppliers in an affected area.

Q. We anticipate our providers/suppliers will request assistance to stop recoupments by phone (via the customer contact center) since they are unable to coordinate a written request at this time. Does CMS concur we should accept the request over the phone and stop the recoupment until the provider is able to submit a redetermination request form? If so, is there any specific information CMS feels the providers/ suppliers needs to provide to honor a phone request?

A. If a provider/supplier requests relief via phone, the MAC/DME MAC can accept the request and the parties in need of debt payment relief shall submit the written request when mail service resumes. The party shall provide the provider's name/number, facility address, and overpayment details.

Q. Can CMS advise what status code MACs should use in the Healthcare Integrated General Ledger Accounting System (HIGLAS) to stop recoupment for these requests?

A. The MAC/DME MAC can use the HLD-CMS status code until the appeal has been received.

Q. How long should the MACs/DME MACs wait to receive an appeal request before removing the stop recoupment?

A. Sixty days is adequate as a minimum for providing relief for affected appellants. If recoupment occurs after this 60-day timeframe and an appellant can provide attestation that they are still unable to submit a proper appeal request, CMS may also allow an adjustment to the interest, as indicated in the response to the next question.

Q. How would CMS prefer the MACs/DME MACs handle a request to stop a recoupment if the offset already occurred?

A. If the recoupment occurred prior to the approval of debt relief, no adjustments shall be made. If the recoupment occurred after approval of debt relief, adjustments shall be made to adjust the interest.

Q. What status code should MACs/DME MACs use when they are removing the stop recoupment when an appeal has not been received?

A. The MACs/DME MACs shall use the status code that the debt was assigned before the HLD-CMS status code was placed.

Q. While good cause typically does not define a timeframe, is CMS going to provide a timeframe for how long MACs/DME MACs would honor extensions for untimely appeals requests related to the natural disasters?

A. MACs/DME MACs may extend the timeframe for filing an appeal if good cause is found. Contractors should find guidance related to Conditions and Examples that may Establish Good Cause for Late Filing in §240.3 of the *Claims Processing Manual, Chapter 29, Appeals of Claims Decisions*.

Q. If an appeal extension request is received that does not provide enough information to identify the claims in question, MACs/DME MACs would not be able to honor the request because we do not have the required information to reference back to once the official appeal request is received at a later date.

A. MACs/DME MACs shall contact the provider/supplier and inform them of the inability to process the claim appeal due to the lack of identifying information. Allow the provider/ supplier the opportunity to submit the information (via phone, fax, or mail), or to provide details that would allow the MAC/DME MAC to identify the claim. The provider/ supplier should also include an attestation statement in case the supporting information was destroyed in the natural disaster and cannot be reproduced.

Q. Are the guidelines related to recoupment are for 935 debts only?

A. The guidelines relate to all non-Medicare secondary payer debts.

Situation 2: The MAC/DME MAC has requested, or needs to request, additional documentation for a pending appeal, but the provider/supplier/beneficiary has been impacted by a natural disaster.

Action: The MAC/DME MAC shall hold the request until the documentation can be obtained or submitted. However, to the extent that the Contractor can use other data sources that are available to substantiate payment for the claim, it should do so. The CMS will waive the timeliness requirements for processing these appeals.

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Questions:

Q. If the MAC/DME MAC researches all sources and is still not able to process the appeal without additional documentation, will CMS define a timeframe whereby the MAC sends a follow-up request and/or closes the appeal if no response is received?

A. If the appellant is unable to provide the additional documentation within 60 days and can provide attestation that they are still unable to submit the documentation, the MAC/DME MAC shall allow additional time and keep track of the volume of appeals impacted. Also, please include the volume in the monthly status reports.

Q. How does CMS want appeals handled when there are no other data sources available for the MAC/DME MAC to substantiate payment and a response is received from the customer indicating the records cannot be obtained/are not available/cannot be recreated?

A. The MAC/DME MAC should reach out to the provider/supplier and request a signed attestation statement that the services were provided, but records were destroyed during the natural disaster and cannot be recreated by other means. In the case of complete destruction of medical records where no backup records exist, MACs/DME MACs shall accept an attestation that no medical records exist and consider the services covered and correctly coded.

Q. We are seeking direction in regards to automated pre-pay denials (e.g., local coverage determination (LCD) or national coverage determination (NCD). An example is the service initially denied for the procedure to diagnosis relationship. There is no information submitted with the appeal other than the attestation that medical records were destroyed. Additionally, there are NCDs that are hard coded in the shared system that cannot be overridden/bypassed. Does CMS concur that these should continue to be denied and the appeal affirmed?

A. In the case of complete destruction of medical records where no backup records exist, MACs/DME MACs and recovery auditors shall accept an attestation that no medical records exist and consider the services covered and correctly coded. An attestation is required for the file, as documentation for future audits.

Situation 3: A request for an appeal filed by an appointed representative on behalf of a party contains a missing or defective appointment instrument and the party is in the affected area.

Action: The contractor shall process the request and attempt to obtain the corrected appointment instrument. If the corrected appointment instrument is not received by the end of the appeals adjudication period, Contractors shall mail the redetermination decision letter to the party and not to the purported representative.

Questions:

There were no questions received in regards to Situation 3.

Situation 4: A MAC/DME MAC receives a request for redetermination from a provider/supplier/beneficiary in the affected area and the request is missing some of the required elements, including the appellant's signature, to make it a valid request. However, the MAC/DME MAC has information in the shared systems that would allow it to identify the missing element(s).

Action: The MAC/DME MAC shall accept and process the request, using information already available to it via the shared system. In the case of a missing signature, MAC/DME MAC shall accept and process the request, and attempt to obtain the appellant's signature when mail service resumes.

Questions:

Q. If the MAC/DME MAC receives a written request from a provider/supplier meeting all appeal criteria with the exception of a valid signature, why would the MAC/DME MAC make exception and process the appeal? The person completing the form should be able to include a signature on the request.

A. In the case of a missing signature, the MAC/DME MAC shall accept and process the request, and attempt to obtain the appellant's signature when mail service resumes.

Q. The instruction to attempt to obtain the appellant's signature after the appeal is completed is a manually intensive effort (see next question) to track the cases and complete the follow-up development. Also, for unfavorable completed cases, jurisdiction will have already moved to the qualified independent contractor (QIC) level. Would CMS consider waiving this direction?

A. Given the circumstances, in the case of a missing signature, the MAC/DME MAC shall accept and process the request, and attempt to obtain the appellant's signature when mail service resumes. With respect to the second point raised regarding jurisdiction, CMS agrees that once the QIC receives the request, jurisdiction for the appeal no longer rests with the MAC/DME MAC.

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Hurricane Irma and Medicare disaster-related US Virgin Islands, Puerto Rico, and Florida claims

***Note**: This article was revised December 13, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired December 2, 2017, for Florida and December 3, 2017, for the United States Virgin Islands and the Commonwealth of Puerto Rico. All other information remains the same. This information was previously published in the September 2017 Medicare B Connection, pages 1, 25-27.*

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida who were affected by Hurricane Irma.

Provider action needed

On September 5, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida. Also on September 6, 2017, for the United States Virgin Islands and commonwealth of Puerto Rico and September 7, 2017, for the state of Florida, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 5, 2017, for the United States Virgin Islands and commonwealth of Puerto Rico, and retroactive to September 4, 2017, for the state of Florida. The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired December 2, 2017, for Florida and December 3, 2017, for the United States Virgin Islands and the Commonwealth of Puerto Rico.

On September 7, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted counties and geographical areas of the United States Virgin Islands, commonwealth of Puerto Rico and state of Florida. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional blanket waiver requests are being reviewed. The most current waiver information can be found under *Administrative Actions* at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. This article will be updated as additional waivers are approved. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the United States Virgin Islands, and commonwealth of Puerto Rico from September 5, 2017, and the state of Florida from September 4,

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Q. After the MAC/DME MAC attempts to obtain the appellant's signature, how long should the MAC/DME MAC wait for a response? If the response is not received after a certain time period/attempts should the attempts cease?

A. Given the circumstances, in the case of a missing signature, the MAC/DME MAC shall accept and process the request, and attempt to obtain the appellant's signature when mail service resumes. If the MAC/DME MAC is unable to obtain the appellant's signature, the MAC/DME MAC can notify their COR/Business Function Lead.

Q. If no response is received and the appeal decision issued was fully or partially favorable, do the MACs/DME MACs need to reopen the case, render a revised decision, and recoup the money?

A. If a MAC/DME MAC issues a fully favorable determination there is no need to reopen and issue a recoupment letter unless the claim is adjusted or reviewed and denied by another entity. Similarly, for partially favorable determinations, there is no need to reopen and issue a recoupment letter unless the claim is adjudicated on appeal at a higher level. Contractors shall follow the process established in Chapter 29.

Q. Will CMS notify the MACs/DME MACs when mail service is resumed?

A. MACs/DME MACs can stay apprised of mail service status via the United States Postal Service website (*https://about.usps.com/news/service-alerts/*).

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2017, for the duration of the emergency. In accordance with CR 6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. The most current information can be found at *https://www.cms.gov/emergency*. Medicare FFS questions & answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida . These Q&As are displayed in two files:

- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida.
- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 6, 2017, for the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a. Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b. Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities

Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in the United States Virgin Islands, commonwealth of Puerto Rico, and state of Florida in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission. (Blanket waiver for all impacted agencies)

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Irma, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to Hurricane Irma. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

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Care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

Emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Irma, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

For more information refer to the *DMEPOS for Medicare Beneficiaries Impacted by an Emergency or Disaste*r fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Facilities quality reporting

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Florida counties, Puerto Rico municipios, or U.S. Virgin Islands county-equivalents, all of which have been designated by the *Federal Emergency Management Agency (FEMA)* as a major disaster county, municipio, or county-equivalent. Further information can be found in the memo on applicability of reporting requirements to certain providers in the *Downloads* section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*.

Appeal administrative relief for areas affected by Hurricane Irma

If you were affected by Hurricane Irma and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

Replacement prescription fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional information

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/*.

The Centers for Disease Control and Prevention released *ICD-10-CM coding advice* to report healthcare encounters in the hurricane aftermath.

Providers may also want to view the *Survey and Certification Frequently Asked Questions* at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
December 13, 2017	The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired December 2, 2017, for Florida and December 3, 2017, for the United States Virgin Islands and the Commonwealth of Puerto Rico. All other information remains the same.
September 19, 2017	The article was revised to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital, to add information on replacement prescription fills of covered Part B drugs, and information on facilities quality reporting. All other information remains the same. All other information remains the same.

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Hurricane Irma and Medicare disaster-related South Carolina and Georgia claims

***Note**: This article was revised December 13, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on December 4, 2017, for South Carolina and December 5, 2017, for Georgia. All other information remains the same. This information was previously published in the September 2017 Medicare B Connection, pages 27-29.*

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the states of South Carolina and Georgia who were affected by Hurricane Irma.

Provider action needed

On September 7, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the state of South Carolina. On September 8, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Irma, an emergency exists in the state of Georgia. Also on September 8, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the states of South Carolina and Georgia and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to September 6, 2017, for the state of South Carolina and retroactive to September 7, 2017, for the state of Georgia. The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired December 4, 2017, for South Carolina and December 5, 2017, for Georgia.

On September 8, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the Social Security Act for the states of South Carolina and Georgia, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the CMS has issued several blanket waivers in the impacted counties and geographical areas of the states of South Carolina and Georgia. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

The most current waiver information can be found under *Administrative Actions* at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of South Carolina from September 6, 2017, and the state of Georgia from September 7, 2017, for the duration of the emergency. In accordance with CR 6451, use of the DR condition code and the CR modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a “formal waiver” including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. The most current information can be found at *https://www.cms.gov/emergency*. Medicare FFS questions & answers (Q&As) posted in the downloads section at the bottom of the Emergency Response and Recovery webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the states of South Carolina and Georgia. These Q&As are displayed in two files:

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Date of change	Description
September 8, 2017	Initial article released.

MLN Matters® Number: SE17022 *Revised*
Article Release Date: December 13, 2017
Related CR Transmittal Number: N/A

Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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- The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in the states of South Carolina and Georgia.
- The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective September 6, 2017, for the state South Carolina and September 7, 2017, for the state of Georgia.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a. Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b. Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **the states of South Carolina and Georgia**. Individual facilities do not need to apply for the following approved blanket waivers:

Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Irma in the states of South Carolina and Georgia in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission. (Blanket waiver for all impacted agencies)

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Irma, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to Hurricane Irma. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the inpatient psychiatric facility prospective payment system for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

Care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital

CMS has determined it is appropriate to issue a blanket waiver to IPPS and other acute care hospitals with excluded distinct part inpatient rehabilitation units that, as a result of Hurricane Irma, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

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Durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Irma, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable as a result of the hurricane.

For more information refer to the *DMEPOS for Medicare Beneficiaries Impacted by an Emergency or Disaster* fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Appeal administrative relief for areas affected by Hurricane Irma

If you were affected by Hurricane Irma and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

Replacement prescription fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional information

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/*.

The Centers for Disease Control and Prevention released *ICD-10-CM coding advice* to report healthcare encounters in the hurricane aftermath.

Providers may also want to view the *Survey and Certification Frequently Asked Questions* at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
December 13, 2017	The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired December 4, 2017, for South Carolina and December 5, 2017, for Georgia. All other information remains the same.
September 19, 2017	The article was revised to include new waivers regarding care for excluded inpatient psychiatric unit patients in the acute care unit of a hospital and care for excluded inpatient rehabilitation unit patients in the acute care unit of a hospital and to add information on replacement prescription fills of covered Part B drugs. All other information remains the same.
September 11, 2017	Initial article released.

MLN Matters® Number: SE17024 *Revised*
Article Release Date: December 13, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Hurricane Harvey and Medicare disaster-related Texas claims

Note: *This article was revised on November 28, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired on November 22, 2017. All other information remains the same. This information was previously published in the September 2017 Medicare B Connection, pages 33-36.*
Note: Editorial corrections made May 23, 2018, to the article release date.

Provider types affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the state of Texas who were affected by Hurricane Harvey.

Provider information available

On August 26, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of Hurricane Harvey, a major disaster exists in the state of Texas, retroactive to August 25, 2017. Also August 26, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the state of Texas and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 25, 2017. The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired November 22, 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) has issued several blanket waivers in the impacted counties and geographical areas of Texas. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional blanket waiver requests are being reviewed. The most current waiver information can be found under *Administrative Actions* at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. This article will be updated as additional waivers are approved. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) waivers

As a result of the aforementioned declaration, CMS has instructed the MACs as follows:

1. Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of Texas from August 25, 2017, for the duration of the emergency. In accordance with CR 6451, use of the DR condition code and the CR modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.
2. The most current information can be found at *https://www.cms.gov/emergency*. Medicare FFS questions & answers (Q&As) posted in the downloads section at the bottom of the *Emergency Response and Recovery* webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the state of Texas. These Q&As are displayed in two files:
   - The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Texas.
   - The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 25, 2017, for Texas.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information revised.

a) Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b) Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **Texas**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of Hurricane Harvey in the state of Texas in 2017. In addition, for certain beneficiaries

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who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)

- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission. (Blanket waiver for all impacted agencies)
- Home health agencies should monitor information posted at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html* under *Administrative Actions* for updates on waivers.

Critical access hospitals

- This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

- CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Harvey, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the hurricane/tropical storm Harvey. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Emergency DMEPOS for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Harvey, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable as a result of the hurricane.

For more information refer to the *Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster* fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Application deadline extended for reclassifications submission to MGCRB

In accordance with *Waiver or Modification of Requirements* under Section 1135 of the Social Security Act issued August 26, 2017, by Secretary Price, CMS is modifying the September 1, 2017, deadline for applications for FY 2019 reclassifications to be submitted to the Medicare Geographic Classification Review Board (MGCRB). CMS is currently granting a 31-day extension to the deadline at § 412.256(a)(2) for the state of Texas. Applications for FY 2019 reclassifications from hospitals in these areas must be received by the MGCRB not later than October 2, 2017.

Deadline extended for IPPS wage index requests

Regarding the FY 2019 wage index, CMS is modifying the September 1, 2017, deadline specified in the FY 2019 hospital wage index development time table for these hospitals to request revisions to and provide documentation for their FY 2015 Worksheet S-3 wage data and CY 2016 occupational mix data, as included in the May 18, 2017, and July 12, 2017, preliminary PUFs, respectively. CMS is currently granting an extension for hospitals in the state of Texas until October 2, 2017. MACs must receive the revision requests and supporting documentation by this date. If hospitals encounter difficulty meeting this extended deadline of October 2, 2017, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Facilities quality reporting

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Texas counties, all of which have been designated by the *Federal Emergency Management Agency (FEMA)* as a major disaster county. Further information can be found in the memo on applicability of reporting requirements to certain providers in the *Downloads* section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*.

Medicare-dependent small, rural hospitals (MDHs)

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017 deadline for Medicare-dependent small, rural hospitals (MDHs) to apply for sole community hospital (SCH) status in advance of the expiration of the MDH program with an effective date of an approval of SCH status that is the day following the expiration date of the MDH program (that is, September 30, 2017 under current law). CMS is currently granting a 31-day extension to the deadline at § 412.92(b)(2)(v) for the state of Texas. If a hospital located in these areas

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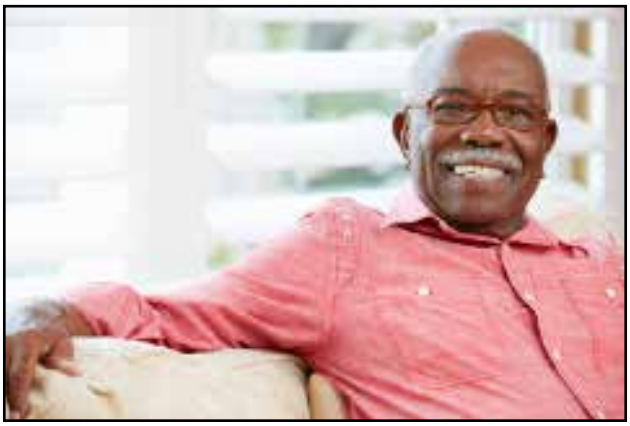
that is classified as an MDH applies for classification as an SCH under the provisions of § 412.92(b)(2)(v), and that hospital's SCH status is approved, the effective date of approval of SCH status will be the day following the expiration date of the MDH program if such hospital applies for classification as a SCH not later than October 2, 2017.



Low-volume hospital

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 26, 2017 by Secretary Price, CMS is modifying the September 1, 2017, deadline for hospitals to make a written request for low-volume hospital status that is received by its Medicare administrative contractor (MAC) in order for the 25 percent low-volume hospital payment adjustment to be applied to payments for its discharges beginning on or after the start of the federal fiscal year (FY) 2018. CMS is currently granting a 31-day extension to the deadline established in the FY 2018 Inpatient Prospective Payment System (IPPS)/LTCH PPS Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (82 FR 38186) for the state of Texas. Requests for low-volume hospital status for FY 2018 from a hospital located in these areas must be received by the MAC no later than October 2, 2017, in order for the low-volume hospital payment adjustment to be applied beginning with the start of the FY 2018 (that is, for discharges occurring on or after October 1, 2017).

Appeal administrative relief for areas affected by Hurricane Harvey

If you were affected by Hurricane Harvey and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

Replacement prescription fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Moratoria on Part B non-emergency ambulance suppliers

CMS has authority under 42 C.F.R. § 424.570(d) to lift a moratorium at any time if the President declares an area a disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act. On August 25, 2017, the President of the United States signed the Presidential Disaster Declaration for several counties in the state of Texas. As a result of the President's declaration CMS has carefully reviewed the potential impact of continued moratorium in Texas and is lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas in order to aid in the disaster response. This lifting applies to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) and became effective September 1, 2017. CMS will also publish a document in the *Federal Register* to announce that the moratoria on Part B non-emergency ambulance suppliers has been lifted. Providers and suppliers that were unable to enroll because of the moratorium will be designated to CMS' high screening level under 42 CFR § 424.518(c)(3)(iii) to the extent these providers and suppliers enroll in Medicare in the future.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional information

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/*.

The Centers for Disease Control and Prevention released ICD-10-CM coding advice to report healthcare encounters in the hurricane aftermath.

Providers may also want to view the *Survey and Certification Frequently Asked Questions* at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
November 28, 2017	The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired November 22, 2017. All other information remains the same.
September 19, 2017	The article was revised to include information about replacement prescription fills of covered Part B drugs. All other information remains the same.

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Tropical storm Harvey and Medicare disaster-related Louisiana claims

Note: *This article was revised November 28, 2017, to advise providers that the public health emergency declaration and Section 1135 waiver authority expired November 22, 2017. All other information remains the same. This information was previously published in the September 2017 Medicare B Connection, pages 37-39.*
Note: Editorial corrections made May 23, 2018, to the article release date.

Provider types affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in the state of Louisiana who were affected by tropical storm Harvey.

Provider information available

On August 28, 2017, pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of tropical storm Harvey, a major disaster exists in the state of Louisiana, retroactive to August 27, 2017. Also on August 28, 2017, Secretary Price of the Department of Health & Human Services declared that a public health emergency exists in the state of Louisiana and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to August 27, 2017. The Public Health Emergency declaration and Social Security Act waivers including the Section 1135 waiver authority expired November 24, 2017.

Under Section 1135 or 1812(f) of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) has issued several blanket waivers in the impacted counties and geographical areas of Louisiana. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if blanket waiver has been issued. Providers can request an individual Section 1135 waiver, if there is no blanket waiver, by following the instructions available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Additional blanket waiver requests are being reviewed. The most current waiver information can be found under *Administrative Actions* at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*. This article will be updated as additional waivers are approved. See the *Background* section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declarations, CMS has instructed the MACs as follows:

1) Change request (CR) 6451 (Transmittal 1784,

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Date of change	Description
September 7, 2017	The article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.
September 5, 2017	The article was revised September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units and lifting the temporary enrollment moratoria on Part B non-emergency ambulance suppliers in Texas. In addition, information has been added to the *Facilities quality reporting* Section and the second paragraph of the *Provider information available* section is modified to clarify that waivers prevent gaps in access to care.
September 1, 2017	The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was added. All other information remained the same.
August 31, 2017	Initial article released.

MLN Matters® Number: SE17020 *Revised*
Article Release Date: November 28, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of Louisiana from August 27, 2017, for the duration of the emergency. In accordance with CR 6451, use of the DR condition code and the CR modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2) The most current information can be found at *https://www.cms.gov/emergency*. Medicare FFS questions & answers (Q&As) posted in the *Downloads* section at the bottom of the *Emergency Response and Recovery* webpage and also referenced below are applicable for items and services furnished to Medicare beneficiaries within the state of Louisiana. These Q&As are displayed in two files:

   - The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in Louisiana.
   - The second file addresses policies and procedures that are applicable only with approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved Section 1135 blanket waivers and approved individual 1135 waivers requested by providers and are effective August 27, 2017, for Louisiana.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information revised.

a) Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b) Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Blanket waivers issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **Louisiana**. Individual facilities do not need to apply for the following approved blanket waivers:

Skilled nursing facilities

- Section 1812(f): Waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of tropical storm Harvey in the state of Louisiana in 2017. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period. (Blanket waiver for all impacted facilities)
- 42 CFR 483.20: Waiver provides relief to skilled nursing facilities on the timeframe requirements for minimum data set assessments and transmission. (Blanket waiver for all impacted facilities)

Home health agencies

- 42 CFR 484.20(c)(1): This waiver provides relief to home health agencies on the timeframes related to OASIS transmission. (Blanket waiver for all impacted agencies)
- Home health agencies should monitor information posted at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html* under *Administrative Actions* for updates on waivers.

Critical access hospitals

This action waives the requirements that critical access hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours. (Blanket waiver for all impacted hospitals)

Housing acute care patients in excluded distinct part units

- CMS has determined it is appropriate to issue a blanket waiver to IPPS hospitals that, as a result of Hurricane Harvey, need to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The IPPS hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the hurricane/tropical storm Harvey. (Blanket waiver for all IPPS hospitals located in the affected areas that need to use distinct part beds for acute care patients as a result of the hurricane.)

Emergency DMEPOS for Medicare beneficiaries impacted by an emergency or disaster

As a result of Hurricane Harvey, CMS has determined it is appropriate to issue a blanket waiver to suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) where DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable. Under this waiver, the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required for replacement. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered

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unusable as a result of the hurricane.

For more information refer to the *Emergency Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Medicare Beneficiaries Impacted by an Emergency or Disaster* fact sheet at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Emergency-DME-Beneficiaries-Hurricanes.pdf*.

Application deadline extended for reclassifications submission to MGCRB

In accordance with Waiver or Modification of Requirements under Section 1135 of the Social Security Act issued August 28, 2017, by Secretary Price, CMS is modifying the September 1, 2017, deadline for applications for FY 2019 reclassifications to be submitted to the Medicare Geographic Classification Review Board (MGCRB). CMS is currently granting a 31-day extension to the deadline at § 412.256(a)(2) for the state of Louisiana. Applications for FY 2019 reclassifications from hospitals in these areas must be received by the MGCRB not later than October 2, 2017.

Deadline extended for IPPS wage index requests

Regarding the FY 2019 wage index, CMS is modifying the September 1, 2017, deadline specified in the FY 2019 hospital wage index development time table for these hospitals to request revisions to and provide documentation for their FY 2015 Worksheet S-3 wage data and 2016 occupational mix data, as included in the May 18, 2017, and July 12, 2017, preliminary PUFs, respectively. CMS is currently granting an extension for hospitals in the state of Louisiana until October 2, 2017. MACs must receive the revision requests and supporting documentation by this date. If hospitals encounter difficulty meeting this extended deadline of October 2, 2017, hospitals should communicate their concerns to CMS via their MAC, and CMS may consider an additional extension if CMS determines it is warranted.

Facilities quality reporting

CMS is granting exceptions under certain Medicare quality reporting and value-based purchasing programs without having to submit an extraordinary circumstances exception request if they are located in one of the Louisiana parishes, all of which have been designated by the *Federal Emergency Management Agency (FEMA)* as a major disaster county. Further information can be found in the memo on applicability of reporting requirements to certain providers in the *Downloads* section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Hurricanes.html*.

Medicare-dependent small, rural hospitals (MDHs)

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 28, 2017, by Secretary Price, CMS is modifying the September 1, 2017, deadline for Medicare-dependent small, rural hospitals (MDHs) to apply for sole community hospital (SCH) status in advance of the expiration of the MDH program with an effective date of an approval of SCH status that is the day following the expiration date of the MDH program (that is, September 30, 2017, under current law). CMS is currently granting a 31-day extension to the deadline at § 412.92(b)(2)(v) for the state of Louisiana. If a hospital located in these areas that is classified as an MDH applies for classification as an SCH under the provisions of § 412.92(b)(2)(v), and that hospital's SCH status is approved, the effective date of approval of SCH status will be the day following the expiration date of the MDH program if such hospital applies for classification as a SCH not later than October 2, 2017.

Low-volume hospital

In accordance with Waivers or Modifications of Requirements under Section 1135 of the Social Security Act issued August 28, 2017, by Secretary Price, CMS is modifying the September 1, 2017, deadline for hospitals to make a written request for low-volume hospital status that is received by its Medicare administrative contractor (MAC) in order for the 25-percent low-volume hospital payment adjustment to be applied to payments for its discharges beginning on or after the start of the federal fiscal year (FY) 2018. CMS is currently granting a 31-day extension to the deadline established in the FY 2018 Inpatient Prospective Payment System (IPPS)/LTCH PPS Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (82 FR 38186) for the state of Louisiana. Requests for low-volume hospital status for FY 2018 from a hospital located in these areas must be received by the MAC no later than October 2, 2017, in order for the low-volume hospital payment adjustment to be applied beginning with the start of the FY 2018 (that is, for discharges occurring on or after October 1, 2017).

Appeal administrative relief for areas affected by Tropical Storm Harvey

If you were affected by Tropical Storm Harvey and are unable to file an appeal within 120 days from the date of receipt of the remittance advice (RA) that lists the initial determination or will have an extended period of non-receipt of remittance advices that will impact your ability to file an appeal, please contact your Medicare administrative contractor.

Replacement prescription fills

Medicare payment may be permitted for replacement prescription fills (for a quantity up to the amount originally dispensed) of covered Part B drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the emergency.

Requesting an 1135 waiver

Information for requesting an 1135 waiver, when a blanket waiver hasn't been approved, can be found at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

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Additional information

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/*.

The Centers for Disease Control and Prevention released ICD-10-CM coding advice to report healthcare encounters in the hurricane aftermath.

Providers may also want to view the *Survey and Certification Frequently Asked Questions* at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html*.

Document history

Date of change	Description
November 28, 2017	The article was revised to advise providers that the public health emergency declaration and Section 1135 waiver authority expired November 24, 2017. All other information remains the same.
September 19, 2017	The article was revised to include information regarding replacement prescription fills of covered Part B drugs. All other information remains the same.
September 7, 2017	The article was revised to include additional waiver information about emergency durable medical equipment, prosthetics, orthotics, and supplies for Medicare beneficiaries impacted by Hurricane Harvey. All other information remains the same.
September 5, 2017	The article was revised September 5, 2017, to include additional information about housing acute care patients in excluded distinct part units. In addition, information has been added to the *Facilities quality reporting* section and the second paragraph of the *Provider information available* section is modified to clarify that waivers prevent gaps in access to care.
September 1, 2017	The article was revised to include additional waiver information for Medicare-dependent small, rural hospitals and for low-volume hospitals. Information regarding administrative relief related to timely filing of appeals was added. All other information remained the same.
August 31, 2017	Initial article released.

MLN Matters® Number: SE17021 *Revised*
Article Release Date: November 28, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

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.

Medicare fee-for-service response to the 2017 Southern California wildfires

Provider type affected

This *MLN Matters*® special edition article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries, who were affected by the December 2017 wildfires in the state of California.

Provider information available

Pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, President Trump declared that, as a result of the effects of the December 2017 Wildfires, an emergency exists in the state of California.

On December 11, 2017, Acting Secretary Hargan of the Department of Health & Human Services declared that a public health emergency (PHE) exists in the State of California retroactive to December 4, 2017, and authorized waivers and modifications under §1135 of the Social Security Act.

On December 13, 2017, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for the state of California retroactive to December 4, 2017 for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of wildfires. Providers can request an individual Section 1135 waiver by following the instructions available at *https://www.cms.gov/About-CMS/Agency- Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declaration, CMS has instructed MACs as follows:

Change request (CR) 6451 (Transmittal 1784, Publication 100-04) issued July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the state of California retroactive to December 4, 2017, for the duration of the emergency. In accordance with CR 6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

The most current information is available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html*.

Also referenced below are Q&As that are applicable for items and services furnished to Medicare beneficiaries within the state of California. These Q&As are displayed in two files:

- One file addresses policies and procedures that are applicable **without** any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency.
- Another file addresses policies and procedures that are applicable **only with** approved Section 1135 waivers or, when applicable, approved Section 1812(f) waivers. These Q&As are applicable for approved individual 1135 waivers requested by providers for California.

In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information is revised.

a) Q&As applicable **without any Section 1135** or other formal waiver are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf*.

b) Q&As applicable **only with a Section 1135** waiver or, when applicable, a Section 1812(f) waiver, are available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf*.

Waiver for California

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued the following waiver in the affected areas of California. **Individual facilities do not need to apply for the following approved waiver**.

Skilled nursing facilities

- 1812(f): This waiver of the requirement for a three-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of the wildfires. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).
- In addition, the waiver provides temporary emergency coverage of SNF services that are not post-hospital SNF services under the authority in §1812(f) of the Social Security Act (the Act), for those people who are evacuated, transferred, or otherwise dislocated as a result of the effects in the state of California, in December 2017. In addition, this waiver provides authority under §1812(f) of the Act to provide coverage for extended care services which will not require a new spell of illness in order to renew provision of services

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by a SNF. These temporary emergency policies would apply to the timeframes specified in the waiver(s) issued under §1135 of the Act in connection with the effects of the wildfires in the state of California in December 2017. Accordingly, both the effective date and expiration date for these temporary emergency policies are the same as those specified pursuant to the §1135 waivers. Further, unlike the policies authorized directly under the §1135 waiver authority itself, the two policies described above would not be limited to beneficiaries who have been relocated within areas that have been designated as emergency areas. Instead, the policies would apply to all beneficiaries who were evacuated from an emergency area as a result of the effects of the wildfires in California in December 2017, regardless of where the "host" SNF providing post-disaster care is located.

Administrative relief

Appeal administrative relief for areas affected by California wildfires

If you were affected by the California wildfires and are unable to file a timely appeal, respond to pending requests for documentation, or experience an interruption in the receipt of the remittance advice (RA) that lists the initial determination(s), please contact your MAC.

Requesting an 1135 Waiver

Information for requesting an 1135 waiver is available at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Requesting-an-1135-Waiver-Updated-11-16-2016.pdf*.

More information is available in the 1135 Waiver letter, which is posted in the *Downloads* section at *https://www.cms.gov/About-CMS/Agency-Information/Emergency/Wildfires.html*.

Additional information

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
December 18, 2017	Initial article released.

MLN Matters® Number: SE17037
Article Revised Date: December 18, 2017
Related CR Transmittal Number: N/A
Related Change Request (CR) Number: N/A
Effective Date: N/A
Implementation Date: N/A

Provider enrollment application fee amount for 2018

On December 4, CMS issued a notice: Provider Enrollment Application Fee Amount for Calendar Year 2018 [CMS–6075–N]. Effective January 1, 2018, the CY 2018 application fee is $569 for institutional providers that are:

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

This fee is required with any enrollment application submitted from January 1, 2018, through December 31, 2018.

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.

New Medicare cards will be mailed between April 2018 and April 2019. Resources are available to prepare you for this change at *https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp*.

New LCDs

Cystatin C measurement – new Part A and B LCD

LCD ID number: L37561 (Florida, Puerto Rico/ U.S. Virgin Islands)

This local coverage determination (LCD) was developed based on data analysis by the Program Safeguards Communication Group (PSCG). Cystatin C (*Current Procedural Terminology* [CPT®] code 82610) was identified as aberrant in Florida when compared to the nation. Cystatin C has been proposed and investigated as an improved marker of renal function and as a potential alternative to serum creatinine based estimated glomerular filtration rate (eGFR), as well as a biomarker for predicting cardiovascular risk. Due to the risk for a high dollar claim payment error and lack of quality evidence for many proposed indications, the LCD for Cystatin C Measurement has been created.

This LCD outlines indications and limitations of coverage and/or medical necessity of cystatin C measurement for calculation of eGFR, non-coverage of cystatin C measurement for cardiovascular risk prediction, CPT® codes, ICD-10-CM diagnosis codes, documentation guidelines, and utilization guidelines.

Effective date

This LCD is effective for services rendered **on or after February 2, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Electroretinography (ERG) – new Part A and Part B LCD

LCD ID number: L37398 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for Electroretinography (ERG) was developed with the intention to allow the utilization of electroretinography to diagnose loss of retinal function or distinguish between retinal lesions and optic nerve lesions and to detect chloroquine (Aralen) and hydroxychloroquine (Plaquenil) toxicity. The LCD does not support the use of ERG for either the diagnosis or management of glaucoma.

Effective date

This new LCD is effective for services rendered **on or after February 2, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Revisions to LCD

Abatacept – revision to the Part A and Part B LCD

LCD ID number: L33257 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for abatacept was revised based on a reconsideration request. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to add the Food and Drug Administration (FDA) approved indication for active psoriatic arthritis in adults. In addition, ICD-10-CM diagnosis codes L40.50, L40.51, L40.52, L40.53, and L40.59 were added to the *ICD-10 Codes that Support Medical Necessity* section of the LCD for Healthcare Common Procedure Coding System (HCPCS) code J0129. Also, the *Sources of Information and Basis for Decision* section of the LCD was updated.

Effective date

This LCD revision is effective for claims processed on or after **January 2, 2018**, for services rendered **on or after June 30, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

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

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

Based on an annual review of the local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications, it was determined that some of the italicized language throughout the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after December 7, 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*.

Colorectal cancer screening and screening and diagnostic mammography – revision to the Part A and Part B LCD

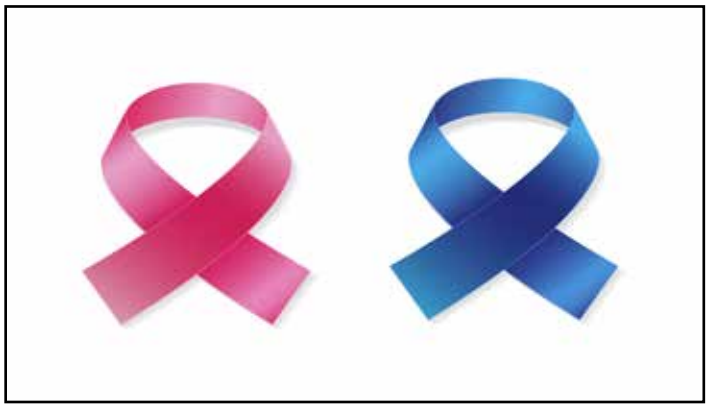
LCD ID number: L36355 and L36342 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 10181, replacement of mammography Healthcare Common Procedure Coding System (HCPCS) codes, waiver of coinsurance and deductible for preventive and other services, and addition of anesthesia and prolonged preventive services, the local coverage determinations (LCDs) for colorectal cancer screening and screening and diagnostic mammography were revised.

Language in the colorectal cancer screening LCD was revised in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD. Language for anesthesia services was revised to delete *Current Procedural Terminology* (CPT®) code 00810 and replace it with CPT® codes 00811 and 00812.

The screening and diagnostic mammography LCD was revised in the *CPT®/HCPCS Codes* and *ICD-10 Codes that Support Medical Necessity - paragraph* sections of the LCD to delete HCPCS code G0202 and replace it with CPT® code 77067, delete HCPCS code G0204 and replace it with CPT® code 77066, and delete HCPCS code G0206 and replace it with CPT® code 77065.

Furthermore, the *CPT®/HCPCS Codes* section of the screening and diagnostic mammography LCD was revised to remove CPT®/HCPCS codes 77065, 77066, and G0279 from the *Group 1 Codes* section of the LCD and add them



as *Group 2 Codes* to be consistent with the groups in the *ICD-10 Codes that Support Medical Necessity* section of the LCD.

Effective date

The LCD revisions, based on CR 10181, are effective for services rendered **on or after January 1, 2018.** The additional revision to the screening and diagnostic mammography LCD is effective for claims processed **on or after January 1, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Computed tomographic angiography of the chest, heart and coronary arteries – revision to the Part A and Part B LCD

LCD ID number: L33282 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for computed tomographic angiography of the chest, heart and coronary arteries was revised based on a reconsideration request. The LCD was revised to add ICD-10-CM diagnosis codes I35.0, I35.1, I35.2, I35.8, and Z01.810 in the *ICD-10 Codes that Support Medical Necessity* section of the LCD for *Current Procedural Terminology* (CPT®) code 71275. Also, an explanation that all the codes within the asterisked range from the first code to the last code apply for ICD-10-CM code range I26.xx was added in the *Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation* section of the LCD. 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 January 2, 2018.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

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

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

The local coverage determination (LCD) for controlled substance monitoring and drugs of abuse testing was revised based on an external correspondence inquiry. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD was revised to remove the parent drugs and metabolite chart.

Effective date

This LCD revision is effective for services rendered **on or after December 12, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the

"Section Navigation" drop-down menu at the top of the LCD page..

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

Long-term wearable electrocardiographic monitoring (WEM) – revision to the Part A and Part B LCD

LCD ID number: L33380 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for long-term wearable electrocardiographic monitoring (WEM) was revised based on a reconsideration request. The *Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) Codes* section of the LCD was revised to remove CPT® codes 0295T-0298T from the *Group 1 Paragraph* section of the LCD and add them to the *Group 1 Codes* section of the LCD. Also, the *ICD-10 Codes that Support Medical Necessity* section of the LCD was updated to add CPT® codes 0295T-0298T to the *Group 1 Paragraph* section of the LCD. In addition, the *Sources of Information and Basis for Decision* section of the LCD was updated. Furthermore, the *CPT®/HCPCS Codes* section of the LCD was revised to remove CPT® codes 93268-93272 from the *Group 1 Codes* section of the LCD and add them as *Group 2 Codes* to be consistent with the groups in the *ICD-10 Codes that Support Medical Necessity* section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after October 24, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" 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 (procedure codes 0387T, 0389T-0391T) – revision to the Part A and Part B LCD

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

Effective January 18, 2017, the Centers for Medicare & Medicaid Services (CMS) covers leadless pacemakers through coverage with evidence development (CED). CMS covers leadless pacemakers when procedures are performed in Food and Drug Administration (FDA) approved studies. CMS also covers, in prospective longitudinal studies, leadless pacemakers that are used in accordance with the FDA approved label for devices that have either: an associated ongoing FDA approved post-approval study; or completed an FDA post-approval study. Leadless pacemakers are non-covered when furnished outside of a CMS approved CED study.

Based on the change request (CR) 10117 (national coverage determination (NCD 20.8.4); Leadless Pacemakers), the noncovered services local coverage determination (LCD) has been revised to remove Current Procedural Terminology (CPT®) codes 0387T, 0389T, 0390T, and 0391T from the "CPT®/HCPCS Codes" section of the LCD under the subtitle "Procedures for Part A and Part B."

Effective date

This LCD revision is effective for claims processed **on or after January 2, 2018**, for services rendered **on or after January 18, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Noncovered services – revision to the Part A and Part B local coverage article

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

The noncovered services local coverage article for the sources of information and basis for decision (A52928) was updated to add 15 published sources from previous reconsideration requests (received in July 2015 and October 2016) for Healthcare Common Procedure Coding System (HCPCS)/*Current Procedural Terminology*® (CPT®) codes C9737/43284/43285/43289 for magnetic band augmentation of the lower esophageal sphincter (LINX). Additionally, the noncovered services local coverage determination (LCD) revision history was updated; however, the content of the LCD was not revised in response to the reconsideration requests.

Effective date

This local coverage article revision is effective for services rendered **on or after November 30, 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*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the Part A and B LCD

LCD ID number: L33751 (Florida, Puerto Rico/ U.S. Virgin Islands)

The scanning computerized ophthalmic diagnostic imaging (SCODI) local coverage determination (LCD) was revised as a collaborative effort with Novitas to have standardized coverage amongst both Medicare administrative contractors (MACs) for jurisdictions JH, JL, and JN.

The LCD was revised to update the following sections: *Coverage Indications, Limitations and/or Medical Necessity*, *History/Background and/or General Information*, *Covered Indications*, *Limitations*, *CPT/HCPCS Codes*, *ICD-10 Codes that Support Medical Necessity*, *Documentation Requirements*, *Utilization Guidelines*, and *Sources of Information and Basis for Decision*. In addition, the following sections were added to the LCD: *Summary of Evidence* and *Analysis of Evidence (Rationale for Determination)*.

Language in the LCD was revised to address the reasonable and necessary requirements for SCODI procedures. Diagnosis codes were revised due to inappropriate codes in the LCD following ICD-10-CM transition. Additional requirements were added to the *Documentation Requirements* section of the LCD. Finally, utilization parameters were added to the *Utilization Guidelines* section of the LCD for patients whose primary ophthalmological condition is related to a retinal disease and patients with retinal conditions undergoing active intravitreal drug treatment.

Effective date

This LCD revision is effective for services rendered **on or after January 25, 2018.** 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*.

Serum phosphorus – revision to the Part A and Part B LCD

LCD ID number: L34022 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on an annual review of the local coverage determination (LCD) for serum phosphorus, it was determined that some of the italicized language throughout the LCD does not represent direct quotations from the Centers for Medicare & Medicaid Services (CMS) sources listed in the LCD; therefore, this LCD is being revised to assure consistency with the CMS sources.

Effective date

This LCD revision is effective for services rendered **on or after December 7, 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*.

Wound care – revision to the Part A and Part B LCD

LCD ID number: L37166 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for wound care was revised to add revenue codes 0982 and 0983 to the "Revenue Codes" section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after December 7, 2017.** LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting "Related Local Coverage Documents" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Additional Information

2018 HCPCS Part A/B, Part A and Part B local coverage determination changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2018 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted. The following is a list of the impacted LCDs.

Part A/B Combined LCDs

L33261 Allergy Testing

L36767 Aortography and peripheral angiography

L36499 BRCA1 and BRCA2 Genetic Testing

L36355 Colorectal Cancer Screening

L36393 Controlled Substance Monitoring and Drugs of Abuse Testing

L33586 Gene Expression Profiling Panel for use in the Management of Breast Cancer Treatment

L33684 Hemophilia Clotting Factors

L34007 Intravenous Immune Globulin

L33382 Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions

L34519 Molecular Pathology Procedures

L33777 Noncovered Services

L33707 Pulmonary Diagnostic Services

L36342 Screening and Diagnostic Mammography

L33413 Therapy and Rehabilitation Services

L33414 Topical Photosensitizers used with PDT for Actinic Keratoses and Certain Skin Cancers

L33762 Treatment of varicose veins of the lower extremity

L33767 Viscosupplementation Therapy for Knee

Part A only LCD

L33972 Psychiatric Partial Hospitalization Program

Part B only LCD

L33834 Health and Behavior Assessment/Intervention

L33910 Independent Diagnostic Testing Facility (IDTF)

Effective date

These LCD revisions are effective for services rendered **on or after January 1, 2018**. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

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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.

New Medicare cards will be mailed between April 2018 and April 2019. Resources are available to prepare you for this change at *https://medicare.fcso.com/Claim_submission_guidelines/0380240.asp*.

Upcoming provider outreach and educational events

Topic: Internet-based PECOS training by appointment

Date/time: By appointment
Type of Event: Face-to-face
https://medicare.fcso.com/Events/0324673.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 *https://gm1.geolearning.com/geonext/fcso/opensite.geo*, 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 *MLN Connects*® to its membership as appropriate.

MLN Connects® for November 22, 2017

MLN Connects® for November 22, 2017
View this edition as a PDF

News & Announcements

- Medicare Clinical Laboratory Fee Schedule: Final CY 2018 Payment Rates
- National Rural Health Day
- 2017 Medicare FFS Improper Payment Rate Below 10 Percent for First Time Since 2013
- CMS Measures Inventory Tool
- 2016 PQRS Feedback Reports and Annual QRURs: Informal Review Period Ends December 1
- Hospice Compare: Guidance on Updating Demographic Data
- Hospice Compare Refresh Delayed
- Submit Suggestions for Precedential Medicare Appeals Council Decisions
- IPPS Hospitals: Review FY 2014 and FY 2015 Worksheet S-10 Cost Report Data
- Recommend Influenza Vaccination: Each Office Visit is an Opportunity

Provider Compliance

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

Upcoming Events

- Revisions to DMEPOS Quality Standards for Therapeutic Shoe Inserts Special Open Door Forum — November 28
- Quality Payment Program Year 2 Final Rule Call — November 30
- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- SNF QRP: Assessment-Based Measures Confidential Feedback Report Webinar — December 6
- LTCH Quality Reporting Program In-Person Training — December 6 and 7
- IMPACT Act Special Open Door Forum — December 12
- National Partnership to Improve Dementia Care and QAPI Call — December 14

Medicare Learning Network Publications & Multimedia

- Medicare Fraud & Abuse Poster — New
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet — Revised
- Medicare Disproportionate Share Hospital Fact Sheet — Revised
- ABCs of the Initial Preventive Physical Examination Educational Tool — Reminder

MLN Connects® for November 30, 2017

MLN Connects® for November 30, 2017

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News & Announcements

- QRDA III Implementation Guide for CY 2018 Performance Period
- DMEPOS: Traveling Beneficiary Clarification
- Hospice Compare Search Function
- World AIDS Day is December 1

Provider Compliance

- Billing for Stem Cell Transplants — Reminder

Upcoming Events

- Medicare Diabetes Prevention Program Model Expansion Call — December 5
- Interdisciplinary Care Teams for Older Adults Webinar — December 7
- National Partnership to Improve Dementia Care and QAPI Call — December 14

Medicare Learning Network Publications & Multimedia

- Quality Payment Program 2017: MIPS ACI Performance Category Web-Based Training Course — New
- SNF Value-Based Purchasing Program Call: Audio Recording and Transcript — New
- Hurricane Harvey and Medicare Disaster Related Texas Claims *MLN Matters®* Article — Updated
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims *MLN Matters®* Article — Updated
- SBIRT Services Booklet — Reminder

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MLN Connects® for December 7, 2017

MLN Connects® for December 7, 2017
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News & Announcements

- First Breakthrough-Designated Test to Detect Extensive Number of Cancer Biomarkers
- CMS Finalizes Comprehensive Care for Joint Replacement Model Changes, Cancels Episode Payment Models & Cardiac Rehabilitation Incentive Payment Model
- Updated Medicare Part D Opioid Drug Mapping Tool
- Quality and Cost Measures under Consideration: CMS Releases List for 2018 Pre-rulemaking
- Hospice Provider Preview Reports: Review by December 30
- Quality Payment Program Hardship Exception Application Deadline: December 31
- IRF and LTCH Provider Preview Reports: Review by January 3
- New PEPPER Available for Short-term Acute Care Hospitals
- Quality Payment Program Resources
- Extreme and Uncontrollable Circumstances Policy for MIPS Clinicians in 2017
- Targeted Probe and Educate Limits MAC Medical Record Reviews
- Medical Record Documentation: Helpful Clinical Templates and Data Elements
- Qualified Medicare Beneficiary: HETS and Remittance Advice
- National Influenza Vaccination Week: December 3 through 9
- National Handwashing Awareness Week: December 3 through 9

Provider Compliance

- Hospital Discharge Day Management Services CMS Provider Minute Video — Reminder

Claims, Pricers & Codes

- January 2018 Average Sales Price Files Available

Upcoming Events

- Medicare Diabetes Prevention Program Model Expansion Orientation Webinar — December 13
- National Partnership to Improve Dementia Care and QAPI Call — December 14
- Home Health QRP: Proposed Removal of Influenza Vaccination Measure from Home Health Quality of Patient Care Star Rating Webinar — December 14

Medicare Learning Network Publications & Multimedia

- DMEPOS Quality Standards Educational Tool – Revised
- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Revised
- Medicare Advance Written Notices of Noncoverage Booklet — Revised
- How to Use the Searchable Medicare Physician Fee Schedule Booklet — Revised
- Long-Term Care Hospital Prospective Payment System Booklet — Revised
- Power Mobility Devices Booklet — Revised

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MLN Connects® for December 14, 2017

MLN Connects® for December 14, 2017

View this edition as a PDF

News & Announcements

- New Medicare Card: Less Than Four Months until Transition Begins
- IRF and LTCH Compare Quarterly Refresh: New Measures Added
- Hospice Compare Quarterly Refresh
- MACRA Measure Development Plan Technical Expert Panel: Submit Nominations by December 20
- Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests: Request for Nominations
- QRDA I Conformance Statement Resource
- Provider Enrollment Application Fee Amount for CY 2018

Provider Compliance

- Payment for Outpatient Services Provided to Beneficiaries Who Are Inpatients of Other Facilities
- Bill Correctly for Device Replacement Procedures

Claims, Pricers & Codes

- If You Submit Paper Claims: Avoid Crossover Issues

Medicare Learning Network Publications & Multimedia

- IRF Medical Review Changes *MLN Matters®* Article — New
- IRF Reference Booklet — New
- Quality Payment Program Call: Audio Recording and Transcript — New
- Hurricane Irma and Medicare Disaster Related United States Virgin Islands, Commonwealth of Puerto Rico and State of Florida Claims *MLN Matters®* Article — Updated
- Hurricane Irma and Medicare Disaster Related South Carolina and Georgia Claims *MLN Matters®* Article — Updated
- December 2017 Catalog — Revised
- IRF Prospective Payment System Booklet — Revised
- DMEPOS Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers Fact Sheet — Revised
- DMEPOS Competitive Bidding Program Traveling Beneficiary Fact Sheet — Revised
- Medical Privacy of Protected Health Information Fact Sheet — Reminder
- Behavioral Health Integration Services Fact Sheet — Reminder
- Medicare Basics: Commonly Used Acronyms Educational Tool — Reminder
- Evaluation and Management Services Web-Based Training Course — Reminder

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MLN Connects® for December 21, 2017

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Editor's Note

Happy holidays from the *MLN Connects®* staff! The next regular edition will be released Thursday, January 4, 2018.

News & Announcements

- 2018 Medicare EHR Incentive Program Payment Adjustment for Eligible Clinicians
- Physician Compare: 2016 Performance Information Available

Provider Compliance

- Medicare Hospital Claims: Avoid Coding Errors – Reminder

Upcoming Events

- Low Volume Appeals Settlement Option Call – January 9

Medicare Learning Network Publications & Multimedia

- Medicare FFS Response to the 2017 Southern California Wildfires *MLN Matters®* Article – New
- Medicare Diabetes Prevention Program Model Call: Audio Recording and Transcript – New
- Hospice Payment System Booklet – Revised
- Ambulance Fee Schedule Fact Sheet – Revised
- Medicare Overpayments Fact Sheet – Revised

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866-454-9007
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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
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Jacksonville, FL 32232-5248

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries

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

Email**:** *EDOC-CS-FLINQB@fcso.com>>*
Online form: *https://medicare.fcso.com/Feedback/161670.asp*

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

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Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
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Medicare secondary payer

Medicare Part B Secondary Payer Dept.
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Jacksonville, FL 32231-4078

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

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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

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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

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

Redeterminations
Medicare Part B Redetermination
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Jacksonville, FL 32232-5024

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Jacksonville, FL 32232-5091

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Part B QIC South Operations
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Jacksonville, FL 32231-4078

Electronic data interchange (EDI)
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Jacksonville, FL 32231-4071

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Jacksonville, FL 32231-4141

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email: *FCSOSPOTHelp@FCSO.com*

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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

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P.O Box 45015
Jacksonville, FL 32232-5015

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PO Box 45300
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General inquiries

First Coast Service Options Inc.
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Email**:** *EDOC-CS-PRINQB@fcso.com>*
Online form: *https://medicare.fcso.com/Feedback/161670.asp*

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Email: *medical.policy@fcso.com*

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Jacksonville, FL 32231-4078

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Jacksonville, FL 32231-4071

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Jacksonville, FL 32231-5040

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